

Study of the California Workers' Compensation Insurance Market

Presented To:



***California Commission on Health and Safety
and Workers' Compensation***

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DRAFT

Foreword and Acknowledgments

The California workers' compensation insurance marketplace is faced with multiple and difficult challenges to stabilize and improve conditions in the next few years.

We hope this report provides some realistic and reasonable recommendations to consider in policymaking as the various parties move forward. Our report and recommendations are based on objective research of ratemaking, pricing and practice on the insurance side.

We also based our recommendations on numerous meetings, conversations, documents and input we received from many interested participants in the system. Ultimately, the people responsible for implementing and monitoring the impact of these recommendations are those with whom we have had discussions over the past six months.

We were honored to have access to so many talented people sharing their time and resources. We could not have completed this report without their assistance.

First and foremost we wish to thank the Commission on Health and Safety and Workers' Compensation (CHSWC), the Commissioners, Christine Baker, Executive Officer, and Commission staff (Judge Joel Gomberg, Kirsten Stromberg, Irina Nemirovsky, Janice Yapdiango, Oliva Vela and Chellah Yanga) for the opportunity to undertake this important project.

We want to offer special thanks to Dave Bellusci and his staff at the California Workers' Compensation Insurance Rating Bureau (WCIRB.) Without their assistance and provision of data, we would not have been able to make the appropriate analysis and review of rate and loss data that make a significant contribution to this report.

Special thanks to Frank Neuhauser for performing a critical piece of this report, that measures claims behavior of active carriers against the behaviors of insolvent carriers. Additional thanks go to Karine Melby, Michelle Langton and Lynne Little from Hays for their invaluable contributions to this report.

Last, but not least, a warm thank you to those listed in Appendix Three. Your input and comments were invaluable in forming the basis for many of the recommendations in this report.

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Executive Summary



The crisis facing the California workers' compensation market is dire. The hope for and belief in simple and painless solutions are unrealistic. As a recent blue ribbon panel in Florida found in their system overview, "The failings of the workers' compensation system are the result of a complex and inter-related set of problems and require a comprehensive, integrated solution."

Although the circumstances facing California are not unique, the scope and extent of the challenge and symptoms faced the state are unprecedented. The solutions can be found,, but it will take some difficult decisions; which are likely to change the fundamental way the worker's compensation system is designed and administered in California.

Policymakers, legislators, regulators and market players need to put aside differences and work to solve this huge challenge in the next year. As each month passes, the strains on the shrinking private market are increasing, medical costs are increasing at an unsustainable rate, and employers are having a more difficult time obtaining overage.

Many challenges face the California marketplace, from the future of CIGA assessments, to the continuing CDI oversight of SCIF financial solvency status to the continuing annual double-digit medical cost inflation. Our recommendations will focus on stabilizing the market. We will recommend administrative and legislative changes to stabilize and improve market capacity and affordability while providing the needed benefits to injured workers.

In July 2003, the WCIRB reported that medical costs and services now comprise the majority (51%) of total loss payments in the California insured market segment for calendar year 2002. At this time, total medical costs increased 28% from \$3.2 billion to \$4.1 billion.

Premium increases in the insured market alone have drained \$17 billion from California insured employers in the past five years, as they have seen annual written gross premiums grow from \$6.6 billion in 1998 to \$15.4 billion in 2002. These figures do not even address the additional cost pressures that self-insured employers have seen in the same time period.

If pricing pressures continue to increase on insureds, the system will likely see an explosion in non-compliance with coverage requirements. Employers will increasingly choose to face uncertain regulatory action rather than the certainty of steep price increases for coverage.

The Commission on Health Safety and Workers' Compensation has and will continue to serve as one of the leaders in identifying and implementing the needed reforms for system stabilization. We hope this report is a timely and valuable tool in providing a number of changes that can have a positive impact on the California workers' compensation system.

When the Commission initiated the background work and decided to move forward with a study on the insurance market challenges, four areas were identified to be covered by this report:

1. Recommend ways to stabilize the market.
2. Identify impacts on insurers and employers.
3. Analyze the effects of market consolidation.
4. Reduce system costs and improve benefit delivery.

We believe our report offers some significant and meaningful recommendations to the challenges facing the California system. Because there are many challenges and the scope of this report request was so broad, we have focused our analysis and recommendations in the following eight areas we believe will help to guide the efforts of policymakers:

1. Ratemaking and Pricing Environment After Deregulation.
2. California System Cost Drivers
 - a. Medical
 - b. Permanent Disability.
3. Solvency Oversight.
4. Administrative and Claims Regulatory Practices.
5. Market Challenges for SCIF.
6. California Insurance Guaranty Association (CIGA).
7. Self-Insurance and Other Market Challenges.
8. Reinsurance.
9. Future Studies.
10. Other

No report can provide recommendations with universal truth and appeal that all parties will endorse. We did, however, make recommendations based on what we believed to be the best approach to addressing each specific area of the crisis we were asked to review.

This report will provide a roadmap for changes that can improve the system. We hope the report will serve as a call to action and allow parties to focus on solutions rather than attempting to place blame. Many people in the system are responsible for actions taken to-date, and those same people are needed to right the system and move it forward to a healthy and functional status.

Each recommendation we make is boxed, numbered and prioritized for ease of reference. In the Summary section of this report beginning on page 121, we have combined and prioritized the recommendations. We believe those higher-level recommendations (A level) will have the most positive system impact if implemented in a timely manner. Similarly, those designated as B-level will have more impact than C-level recommendations.

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Our intent is to segregate recommendations to focus attention and resources where they can provide the largest impact in the coming months. We have also separated each level of the prioritized recommendations into those that require legislative action and those we believe can be implemented in the current regulatory environment through administrative and rule changes.

It appears from our detailed analysis of the ratemaking process that WCIRB created rates, which were within a reasonable degree of accuracy and provided guidance to the industry. Although not wholly adequate, we believe that if the carriers in the California marketplace had adopted the recommended rates plus a reasonable expense factor of approximately 40%, the solvency issues would not have occurred to the extent they have.

Ensuring the ongoing solvency, financial stability and access to affordable coverage for a mandatory insurance product is a necessity in creating a vital employment environment. Controlling cost drivers through medical cost-containment solutions and creating consistency in the PD benefit system are reasonable ways to help keep the California workers' compensation environment healthy and, in turn, ensure that the original compact between workers and employers in the workers' compensation system can be preserved.

As we show later, the nexus for the solvency crisis began with the domestic carriers and moved to the State Fund as they attempted to compete with the irrational pricing practices of the domestics. National carriers were better able to compete as they had a larger surplus position compared to the domestic carriers. In hindsight, the surplus positions of domestic carriers were not as strong as they appeared to be immediately following the switch to open rating.

As development trends worsened, the financial results of monoline domestic carriers became more precarious. This financial situation was compounded by ceding much of their liability to reinsurers who had no reasonable ability to fully honor their contracts. Reserve adequacy and surplus were strained even more, and soon these carriers faced an all-too-common death spiral to insolvency, as they had no other lines or markets to increase profitable writing.

One of the main cost drivers we found was the extreme pressure from medical costs, especially the amounts due to permanent partial cases in the California system. As we also demonstrate later, development of medical costs for PD cases tends to be developing later in the cycle. As this change is occurring over time, it throws off the ability of WCIRB to catch the trend sooner in the ratemaking process.

Medical costs have long been identified as a challenge for California. In the 1992 Workers' Compensation Research Institute (WCRI) California Administrative Inventory, medical costs were identified as a major cost factor driving inflation in system costs. None of the medical cost-control mechanisms implemented in the ensuing decade have

Executive Summary



had a lasting effect on controlling costs. The system has suffered for failing to better understand and effectively address those cost distributions.

In fact, many of the issues and challenges to the California system identified in that WCRI inventory (high number of PD cases, lack of comprehensive fee schedules, utilization, litigation and inconsistency) have not been effectively addressed and remain a factor coloring current perceptions of the system.

Our main regulatory recommendations for ratemaking tend to focus on solvency oversight rather than ratemaking or market conduct. As such, we recommend more active involvement and oversight from the California Department of Insurance (CDI) on solvency monitoring and credit filing review and a reduced role in rate-approval actions going forward.

Some observers of the workers' compensation system ask whether any changes are needed at all, and other observers indicate that the market or insurance cycle will right itself, given adequate time. We believe this is a dangerous and overly optimistic view. There are many issues that have stressed the system to the point of breaking since deregulation occurred in 1994. There are too many remaining stressors from a pricing, cost, availability, financial solvency, guaranty and benefit delivery system that remain unanswered and need to be addressed with a serious and oftentimes difficult mix of solutions.

As the system stands, there is little hope for more competition and cost improvement unless major changes are made to the design and operation of the workers' compensation system. Our recommendations have been designed to give policymakers ideas for improvement that can be made administratively without legislative changes, as well as ideas that do require legislative intent and design.

It is dangerous to assume that this is an insurance cycle issue which, over time, will correct itself. Without any modification to the current system, carriers will be reluctant to commit additional capital or make any investments in California until they have an opportunity to earn a reasonably certain return on their capital investment.

As many participants in the California workers' compensation system have stated and numerous reports and articles show, the current California workers' compensation marketplace is in crisis. There are a number of system design factors affecting the future viability of the workers' compensation system and marketplace. The symptoms we identified as significantly impacting the current market are:

1. The lack of predictability in cost drivers and claims outcomes.
2. The level of current assessments and uncertainty of future additional assessments to support the guaranty fund and the regulatory process.
3. The large number of carrier liquidations in the past four years.

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4. The current split of the market in California between self-insurance, State Compensation Insurance Fund and private carriers, and reinsurance availability, retention levels and costs.
5. The system of penalties for payor mistakes or actions.

These symptoms have all contributed to the current crisis state of the workers' compensation market in California. No one issue is primarily responsible for the current condition of the market place. The interaction of these issues has created a challenging and non-competitive market for workers' compensation. These issues will be discussed in more detail in the main body of this report.

Ratemaking and Pricing Environment After Deregulation

A key factor in any insurance system, especially in the complex workers' compensation system, is the need for predictability of claims outcomes and their associated costs. The key underpinning to ratemaking and the financial stability of the system is the ability to accurately predict the costs and results of injuries in the workplace. This need to predict results in rate adequacy for a system that ensures carriers can provide adequate access and price competition for employers and also provide an opportunity to be profitable.

The California ratemaking system has worked well. The main problem that led to the insurance crisis was the industry reluctance to accurately load expense and profit factors. Trending and development factors were appropriately given by the WCIRB to the industry, but without proper reserving practices and load factors, the recommended rates could never be adequate, and carriers were forced to increase reserves after the fact.

The data reported on reserves and costs were not accurate for the ratemaking process. The upward trend in reserves and ultimate costs each year had a dampening effect on the market and have caused many carriers to restrict or abandon market share in California.

Background

Any study of the California workers' compensation system should separately review the system itself, which is a legislative package of benefits, and the insuring of that system. In the initial portion of this report, we review the insurance portion of the system. Because the system itself is undergoing significant upheaval, we will focus on a subsequent section on several of the more important cost drivers affecting the system.

Not all the system's difficulties are necessarily reflected in the insurance operations and vice versa. Several unusual forces are affecting the insurance segment of the system. We will also focus on the insurance market, highlighting the cause of the recent large number of insurer insolvencies, the accompanying market constriction and the pricing upheavals.

Approach

We developed a picture of the overall condition of the California workers' compensation system and then developed a picture of its condition by comparing it to other states.

Following the analysis of the system are several recommendations addressing the apparent weaknesses of the current system. In developing that analysis, we reviewed both the frequency of claims as well as their severity.

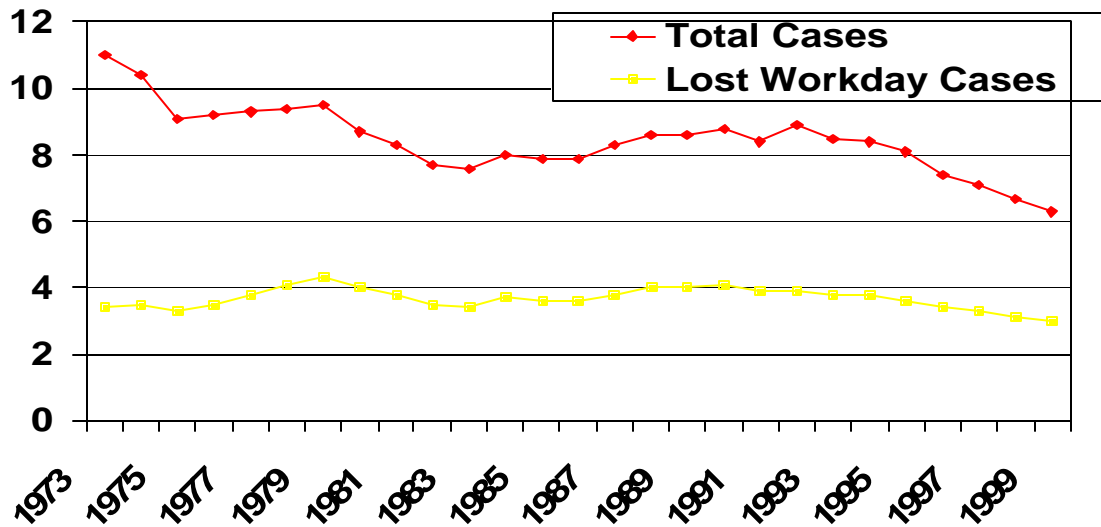
Frequency

On a national basis, as is true with virtually all other states' workers' compensation systems, the frequency of California workers' compensation claims per 100 workers has shown a steady decline since 1990. This trend has been startling in its magnitude and duration.

Chart 1

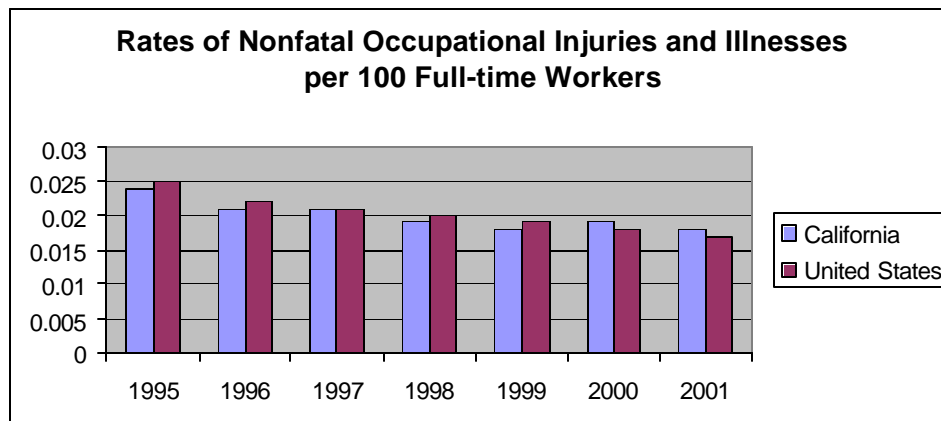
Occupational Injury and Illness

Incidence rates per 100 full-time workers



California occupational injuries and illness frequencies have followed a similar pattern, a steady and, for the most part, continuous decline.

Chart 2



Source: U.S. Department of Labor

The cause of the decline has typically been attributed to two causes, the shift to the less hazardous service industries from the higher hazard manufacturing and heavy industry groups, and the impact of OSHA requirements which were augmented by the introduction in the late eighties of various legislated state-specific safety programs.

However, a review of industry shifts to occupations with lower frequency rates explains only a small portion of the overall frequency decline. In addition, a review of frequency declines in states with mandatory safety legislation and those without any legislation shows virtually the same level of improvement.

According to a 2002 analysis performed by the WCIRB, 67% of the frequency decreases could be explained by Cal/OSHA safety enforcement, a shift to a less hazardous industry mix, slower-than-normal economic growth and an erosion in the level of indemnity levels.

A recent review by the National Council on Compensation Insurance points to individual company safety programs as the cause for the improvement in safety and the decline in accident rates. They found robotics, modular designs, ergonomics, stronger work materials and continued emphasis on workplace safety were critical elements in the improved safety records of the companies reviewed.

In spite of the decreases in claims frequency since 1990, fewer overall work injuries and an increased labor force, overall costs continue to increase with no sign of abating.

Our independent analysis supports the WCIRB NCCI conclusion that the major cause continues to be the introduction of voluntary safety programs that create economically efficient workplaces. Dramatic cost savings can be and have been realized through safety initiatives.

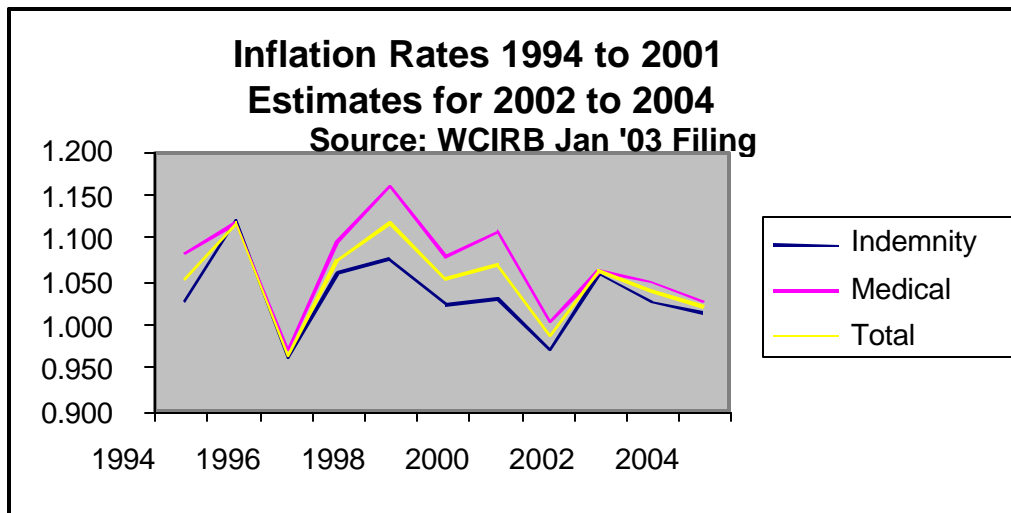
In understanding this drive for safety, it should be kept in mind that the cost of workers' compensation insurance doubled in the 1980's causing corporate America to institute meaningful cost savings through safety in the workplace. This attitude was intensified and augmented with the increase in corporate risk retention in the form of large deductible and self-insurance programs.

In spite of this remarkable decrease in claims frequency since 1990, overall costs for workers' compensation continue to increase both nationally and in California with no sign of abating.

Analysis of Trends in Pure Premium Rates

We analyzed trends in the California workers' compensation system using the standard approach of recasting the historical experience using benefit provisions and premium levels that are currently in effect. The chart below shows underlying medical and indemnity trends from 1973 through 2001 and 2002 to 2004 as projected by the WCIRB.

Chart 3



Except for a 1990 and 1991 spike and a recent spurt in medical costs, the inflationary trends affecting California workers' compensation medical and indemnity costs have been rather consistent.

These trends move differently from CPI indications because they are strongly influenced by both duration and utilization. For instance, a major influence on indemnity costs is the duration of benefits. Changes in the duration of benefits will have a strongly correlated impact on the medical component as well. As a result, the two move in tandem, driven more by duration and utilization than by the individual cost components.

The inflation rates developed above are based on the analysis of results when the actual experience of the past is modified so that current rates and benefit levels are substituted for those in effect during the observed period. This isolates all inflationary impacts, social and economic, in one factor. For most readers familiar with workers' compensation, the close correlation of inflation with the medical and the indemnity portions is not surprising.

By focusing on the period 1994 to 2004, we can see the impact of the cost changes more clearly. Today's benefit and premium levels would have produced a pure premium ratio of 52.3% in 1994; that is, the combined medical and indemnity losses would have consumed only slightly more than one-half of the premium dollars.

Because of the inflationary impact on costs, keeping in mind that we are using the current benefit and premium levels, the projection for 2004 is for a pure premium ratio of 85.3%, or an increase in system costs of 63% in the period from 1994 to 2004.

Ratemaking and Pricing Environment



Although the projected cost increases for the most recent period are substantial, they have moderated somewhat from the very high levels witnessed in the period from 1997 to 2000.

Insuring the System

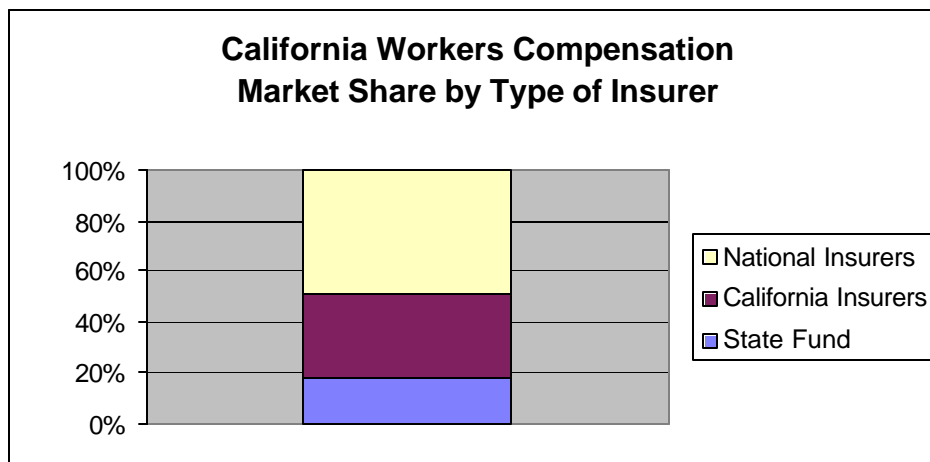
Workers' Compensation Market

In the analysis of the ratemaking and pricing that follows, the reader must keep in mind that this section concerns itself only with the insurance function in the workers' compensation process. The insurance mechanism is only a part of the workers' compensation system and involves only the assumption of obligations that are generated by the workers' compensation benefits as stipulated in the law. As such, it is not concerned with the administration of the system, the efficiency or inefficiency of the delivery of the benefits, or the cost drivers, except to the extent that they are properly evaluated in setting the price for the insurance. These areas will be covered in a subsequent section.

In this analysis, we are concerned with two elements: (1) the ability of the insuring community to develop the proper price for the product it sells; and (2) that community's willingness to charge the proper price. In this section, we will analyze the role of the regulator in this process, as it relates to both the pricing process and the solvency of the insurers.

Although the California market had significant participation from national carriers, the size of the domestic workers' compensation company activity was unusual. As can be seen from the chart below, the participation from domestic carriers in the marketplace was unusually large in California.

Chart 4



Ratemaking and Pricing Environment



Only Florida has had such a strong domestic company influence in the workers' compensation market.¹ The strong domestic market was due in part to the historic minimum rate law, which had as one of its effects the protection of the domestic markets. It did so by using dividends as the main method of competition. Because those dividends could only be paid from the earnings generated from the insurance company and only mature insurance companies have strong earnings in the workers' compensation business, the advantage was with the domestic carriers.

Ratemaking – The Process

The ratemaking process in California follows the national model, a model that is distinctively different from other insurance lines of business in that only one data collection and ratemaking process exists for insurers in any given state and the pricing of the product includes the mandatory use of a portion of each insured's own experience, once an employer's payroll exceeds a certain amount. This process holds whether the rating bureau produces advisory pure premiums, i.e., the benefit payment portion, which is currently the case in California, or full premium rates, which was formerly the national norm, but exists in only a few states today.

The workers' compensation ratemaking system should embody the following in the rates generated: adequate (neither excessive nor inadequate), equitable and not unfairly discriminatory. The California system does this by collecting data in the universally accepted manner, on a summary basis from the insurance companies that use its rates, and on a detailed basis, which forms the basis for both the experience modifications and the basis for the classification relativities which are used to differentiate one type of business from another. As we will see later, some changes should take place in this latter process.

The basic ratemaking system, which is now and has been used over the years in California, has been in use nationally for over fifty years, has been tested continuously over that period, and has gained universal actuarial acceptance. Despite some aberrations, due in most part to changing and difficult-to-measure conditions, the California ratemaking system has worked well, as we will see.

A key factor in any insurance system, especially in the complex workers' compensation system, is the need for predictability of claims outcomes and their associated costs. The key underpinning to ratemaking and the financial stability of the system is the ability to accurately predict the costs associated with injuries in the workplace. The need to accurately predict results provides rate adequacy that allows carriers to provide adequate access and price competition for employers and also provide an opportunity to be profitable.

¹ Interestingly, financial problems have also plagued Florida's domestic carriers: the two largest in 1997, PCA and Riscorp, are no longer in operation.

Ratemaking and Pricing Environment

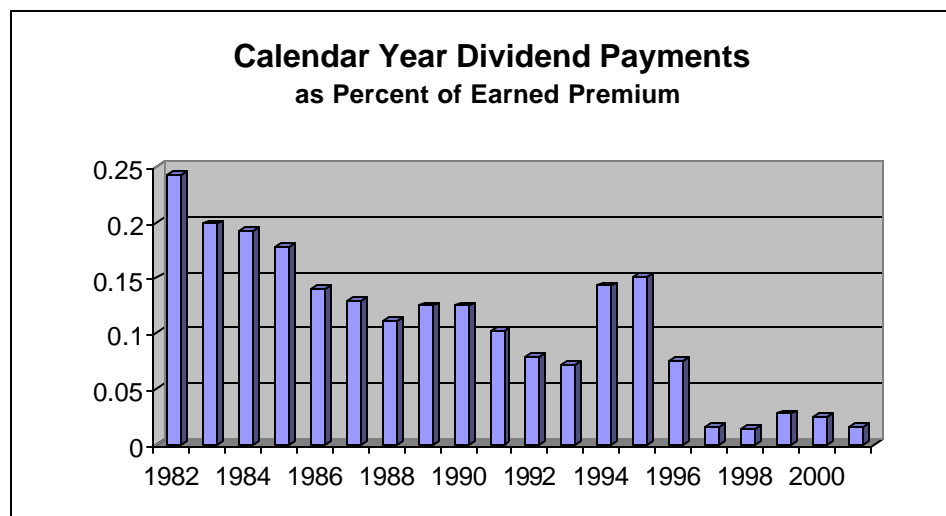


This ratemaking system was formerly a component in a regulatory scheme called the “minimum rate law.” The major thrust of the minimum rate law was essentially to ensure the solvency of the California’s workers’ compensation insurance system, protecting even the least efficient insurer, while fostering competition through the marketplace using the mostly unfettered dividend payments. The dividend process came under some regulatory control when it was required that dividends were only to be paid from “earned” surplus; that is, dividends could only be paid from profits and not from capital.

The system worked well and fostered a large group of domestic insurance companies that were successful for many years. The portion of the premium returned in the form of dividends was substantial.

Chart 5 shows clearly the role played by dividends.

Chart 5



Source: WCIRB

As the chart indicates, the highly competitive early 1980’s saw substantial dividends paid out, reaching almost one-quarter of the earned premium in 1982. This method of competition was largely abandoned with the advent of “open rating,” as can be seen by the rapid drop in dividend payments after open rating took effect in 1995.

Dividend payments were often reflective of the size of a risk and, although not necessarily, were most often tied to loss experience.

The Crisis Emerges

In 1995, California introduced a change in the manner in which rates were promulgated, a change to a more competitive environment. No longer were companies participating in a system where all carriers started with the same rate. Each company would select the appropriate rate by first adopting or filing for a deviation from the advisory loss-cost

Ratemaking and Pricing Environment



portion, or pure premiums, developed by the WCIRB. It would also file for final rates to be charged, rates, which would include provision for their expenses and profit.

The situation that unfolded after the introduction resulted in three areas of concern:

1. Insolvency.
2. Availability.
3. Market Concentration.

Insolvency

What had been a strong domestic market disappeared by the year 2003, with virtually every regional workers' compensation carrier out of business. The market influence of these carriers, which had overpowered the marketplace, has totally disappeared. Although some domestic market capacity continues, it is in no way comparable to the influence and reputation once held by the domestic workers' compensation industry. The list of insolvencies is extensive. The following had the greatest impact on the market:

Superior National
Business Insurance Group
California Compensation
Combined Benefits
Superior Pacific Casualty
Fremont
Industrial Indemnity
HIH
Great States

Sable Insurance Company
PAULA

Availability

During extensive interviews with national carriers, the predominant theme was that California workers' compensation was a market to be avoided. The only California workers' compensation business that the leading national writers were willing to write was termed "accommodation" business, that is, business that is national in scope with a California exposure, or a California risk that involves other than workers' compensation types of business, the insuring of which is of such value that the workers' compensation portion could be "accommodated." Restricted availability leads to unhealthy market concentration, a condition that is not conducive to the proper functioning of regulation through competition.

California was not the first state to deregulate rates for workers' compensation. However, it had the most tumultuous period following the transition to "competitive" rating than

Ratemaking and Pricing Environment



any other state. The question of cause and effect is complex, because of the number of forces at work when limited rate deregulation was introduced. A major force to be considered is that of deregulation itself.

Only a few states have not moved to deregulate workers' compensation rates. Since 1990, the following states have joined the majority of states in using a workers' compensation system that depends more heavily on competition than governmental regulation to control the marketplace

Table1

States Enacting Open Competition Since 1990		
Alabama	Mississippi	Pennsylvania
Alaska	Missouri	South Dakota
Colorado	Montana	Tennessee
Delaware	Nebraska	Texas
District of Columbia	New Hampshire	Utah
Kansas	North Carolina	Virginia
Maine	Oklahoma	

The term "open competition" is applied to all forms of deregulation: from total deregulation, where states allow insurers to set their own costs, which includes both the portion attributable to the payment of benefits and the portion covering the insurer's own expenses, to a system that allows the limited freedom to price for only the insurer's expenses, and the limited freedom to price the benefit payment portion. California combines some of both extremes in a dichotomous, if not oxymoronic, program that regulates "advisory" pure premium while allowing almost complete freedom in setting final rates.

The question as to the role that deregulation played in the crisis is important to review. Because so many states have moved to "open rating," it is appropriate to analyze what occurred in those states in the tumultuous California period 1995 to 2001.

A group of states continues to regulate rates in a "prior approval" regimen, that is, strict rate regulation. A comparison of the three segments, competitive rating states, non-competitive rating states and California, shows that the average combined ratio (the benefit payout plus the insurer's expenses) in the period 1995 to 2001 for the competitive and non-competitive states was almost identical at 112.5% and 112.3%, respectively, while the California combined ratio was 127.7%.

The standard deviation for these years, as a measure of the variability of the markets, was similar for all three. In summary, deregulation does not necessarily cause a disruptive market. In California, the high combined ratio points to a severe pricing problem, which we will see was caused, not by the workers' compensation system itself, but by the insurers and their irresponsible pricing practices.

Table 2

1995 to 2001 Workers' Compensation Calendar Year Experience		
Group	Average Combined Ratio	Standard Deviation from Average
Competitive Rating States	112.5	13.5
Non-Competitive States	112.3	11.9
California	127.7	12.9

Although the 1992 California Rate Commission Study indicated other states did not experience cutthroat competition after implementing open rating, California did. California was overcome by inappropriate pricing, exacerbated by access to cheap reinsurance and carrier loss reserving practices.

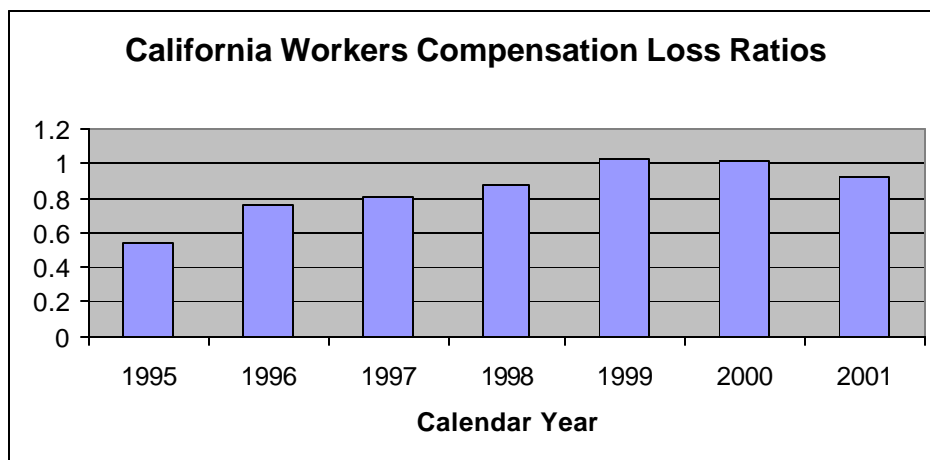
To understand what did happen, it must be appreciated that, the companies were allowed to file for various levels in relation to the “pure premium,” or benefit portion that had been approved by the CDI for use by the companies. In practice, the industry’s expenses range from 19.5% to 31.5% of premium. With a 5% loading for profit, the non-benefit portion of the premium ranges from 24.5% to 36.5% of the final premium.

As a result, a factor of 1.45 times the benefit payments would be necessary to produce an appropriate expense and profit loading. In other words, if the companies were realistically pricing their products, the commonly accepted factors to be used to develop the WCIRB’s filed benefit payment estimates (pure premium or loss costs) to include expenses and profit would range from 1.4 to 1.5.

This would result in a loss ratio from .67 to .71, which would allow for customary expenses and underwriting profit.

The following results occurred in California (Note - ratios are to Standard Earned Premium, the earned premium amount reported to the Bureau, which is consistent with California premium with some minor exceptions):

Chart 6

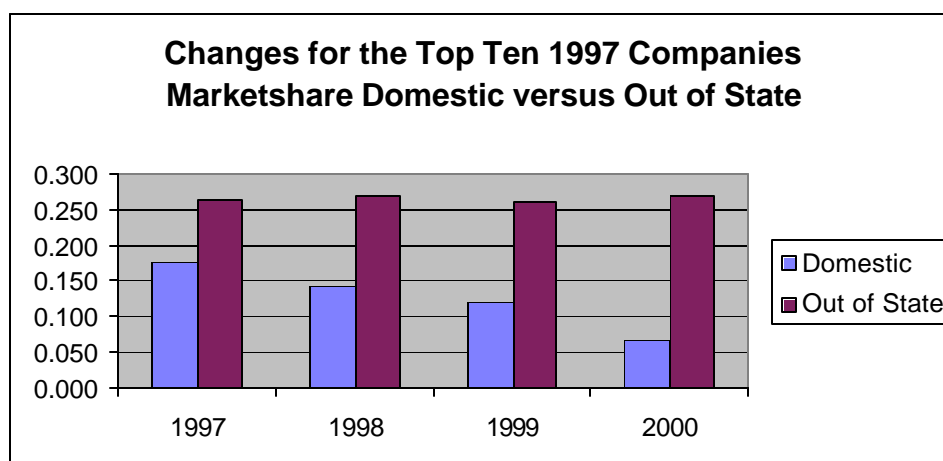


Data Source: WCIRB of California

Market Concentration

A troubling aspect of the crisis is the health of the insurance market. The period 1997 to 2000 saw the top ten companies' percentage of the business move away from the domestic market, while the national or out-of-state market remained constant. We focus on the top ten companies because they are the source of competition. The national company share is largely made up of "accommodation" business, both from national accounts or California multiple line customers.

Chart 7

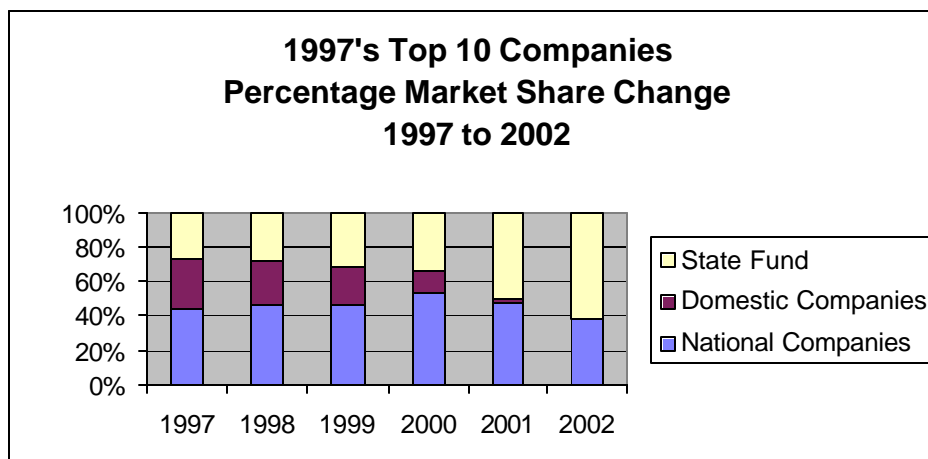


Ratemaking and Pricing Environment



As a result, the State Fund has assumed the predominant role filling the vacuum left by the domestic market, which has disappeared. Meanwhile the National companies refuse to expand.

Chart 8



Only a rebuilt confidence in the fact that unrealistic destructive competition is over and predictable loss costs can be properly priced will bring the market back to a healthy state. Both aspects; destructive competition and predictable loss costs, must be addressed.

Causes of the Crisis

The role that a more competitive rating environment played in the solvency crisis and the ability of the ratemaking system to handle this situation are of the utmost importance.

The main problem that led to the insurance crisis was the industry reluctance to file adequate factors to load expense and profit on the approved pure premium. Pure premiums were appropriately developed by the WCIRB, with the exception of a period when loss reserve adjustments were not fully reflected in the rates, a situation which was subsequently rectified.

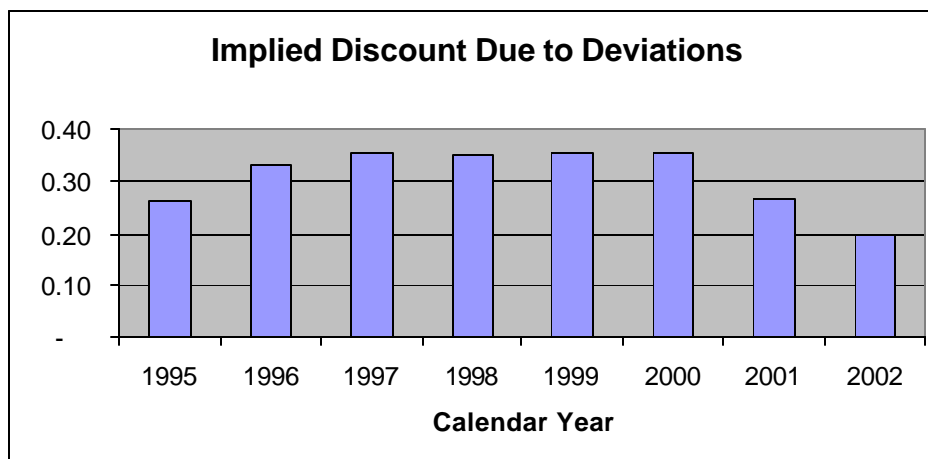
The totally irresponsible pricing that was engendered by the domestic insurance industry² was soon followed by the State Fund, creating an under-pricing binge and a false sense of comfort for the insuring public.

Dividends were quickly replaced as a preferred method of competition by lowering the initial premium charged. Companies deviated from a “profitable” rate by filing low expense factors to be used with the WCIRB’s filed loss portion and combined this with competitive rate credits.³ Their actions resulted in the average charged rates less than the WCIRB’s loss costs, an unbridled destructive competition.

² Zenith National and Fireman’s Fund, both domestic carriers, are national in scope and were not participants in this group’s irresponsible conduct.

The following chart converts the impact of these competitive rate credit actions to amounts similar to dividends.

Chart 9



Source: WCIRB

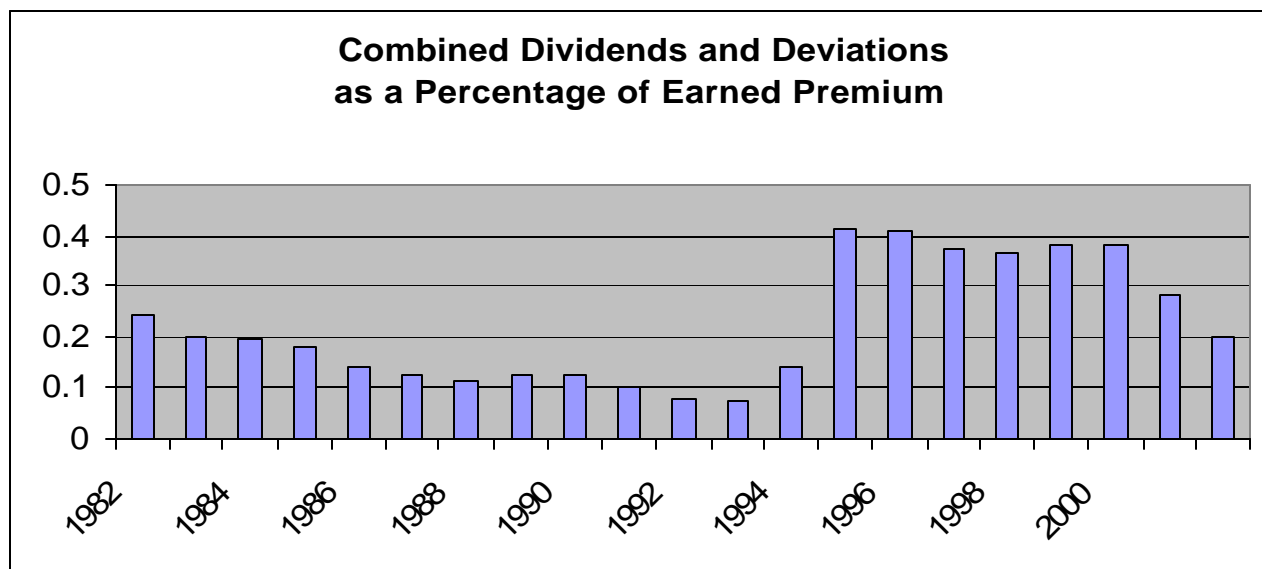
These negative developments, while not seen in other states adopting open rating, should not have been unexpected. As we indicate, the move to open rating in California was done at a time when advisory rates were already inadequate, inexpensive reinsurance was available, and new, naïve capital was entering the market.

There were clear indications and understanding of the pressures California was likely to face as identified by AM Best in 1995. At that time, they stated that “Over the next couple of years, the fierce price competition stemming from open rating will strain balance sheets and make earnings more volatile.”

The following table combines the previous two charts’ results and shows the substantial increase in earned premium discounts after the change from dividends to scheduled rate deviations. Obviously, the impact on pricing of the competitive approach in place immediately after open rating was introduced, and which continues to some extent today, far exceeds the impact from prior dividend levels.

³ The average rate filed with the CDI with the advent of competitive rating was below the cost of the benefits to be paid. The carriers in effect were charging no expense and no profit provision and not all of the benefits that they were contracted to pay out.

Chart 10



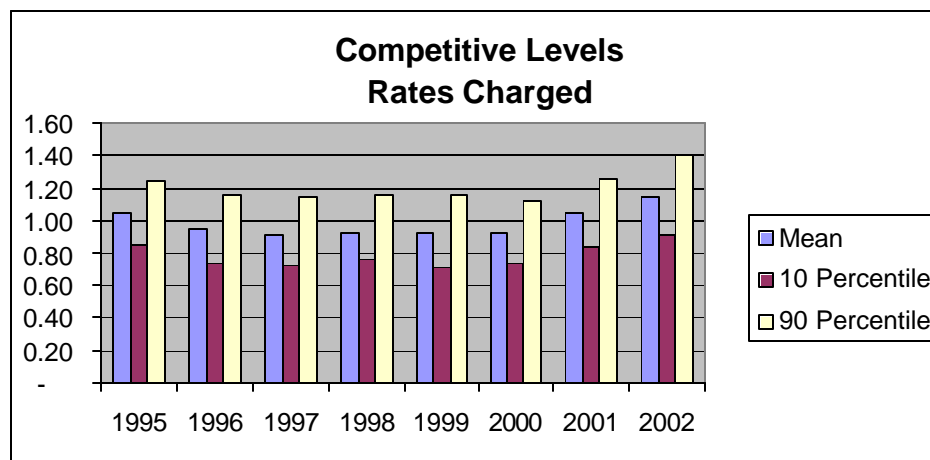
While dividends are more equitable in that they are more often geared to actual loss ratios, the employers across the board benefited more substantially from lower prices fostered under the new system.

Recorded loss ratios after implementation of open rating, point to the use of inadequate rates charged by carriers in the California market. As we noted earlier, the WCIRB advisory pure premium rates, approved by the Department of Insurance, should require a factor from 1.4 to 1.5 to reach an adequate level for the insurers to charge their customers.

However, the net effect of the filings and credits applied were not as high as 1.5, but *were averaging less than 1.0*. In other words, the companies were not collecting sufficient premium to cover the portion that would be paid in benefits, let alone enough to cover expenses and an underwriting profit.

The following chart shows the unweighted average percentage of the filed pure premium, along with the 10th and 90th percentiles for the rates that the companies were charging. The factor for a reasonable rate is 1.43, well above the 90th percentile indication.

Chart 11



It is clear that the insurance industry created its own problem by irrational pricing activity.

How could an entire segment of the market price so irresponsibly? The major domestic carriers, which included Superior National and Fremont, were all subject to similar conditions and forces.

Most companies had been controlled by medical corporations in one form or another. This proved to be naïve capital. The favorable comparison between workers' compensation and group medical, which was being made at the time, was illusory. The differences between these two products are significant and were sufficient enough to cause extreme pricing miscalculations.

At the same time, a significant force that was introduced, again largely supported by the non-workers' compensation insurance market, was a very competitive reinsurance market. A series of misadventures by various ill-intentioned brokers, supported by ill-informed life insurance markets created reinsurance programs that were doomed to failure.

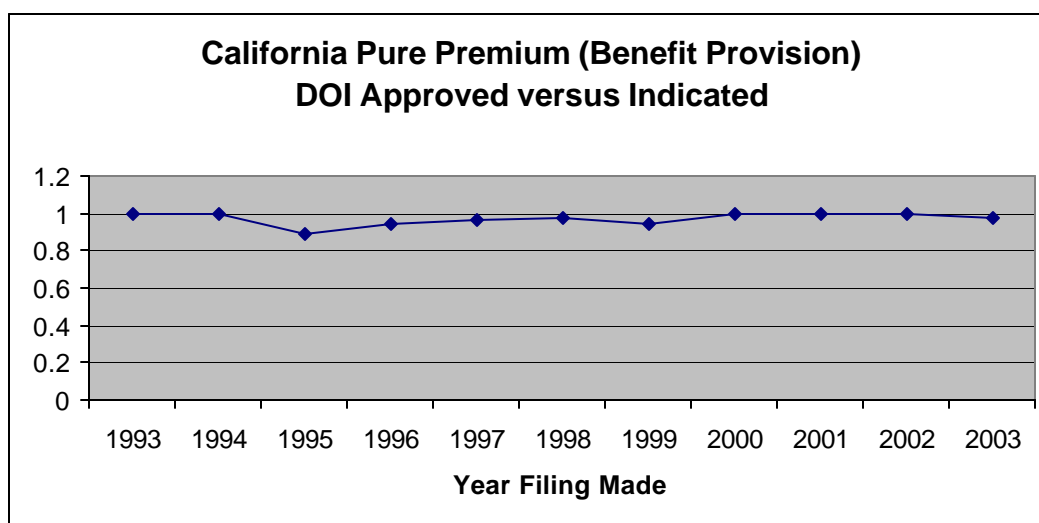
Reinsurance was offered at a price that constituted a small portion of the price of the benefits. This was done by involving a circular scheme of reinsurance on top of reinsurance with reinsurers reinsuring each other on the same business. As a result, California carriers were able to avoid disaster for a short period by ceding the majority of the losses while retaining the large majority of premium. Once these contracts were suspended as their effects became evident, the true cost of workers' compensation insurance became known, and the disastrous consequences began to take a toll in the form of insolvencies.

The Role of the CDI and Recommendations

In hindsight, California could have been more vigilant with the challenges of deregulation. CDI may have taken too much of a hands-off approach to the crisis as it unfolded. California insurance regulators could have taken more proactive oversight on discount plan justification and, as we recommend, taken a much more aggressive approach to solvency regulation.

The role of CDI is important in the question of rate adequacy. CDI had reduced the inadequate rates submitted by the WCIRB immediately prior to the inauguration of open competition and had subsequently reduced the loss portion that could be used by companies. The following chart shows the impact of the CDI's actions.

Chart 12



As can be seen, the reductions to indicated rates by the CDI, which appeared to be a concern at the time they were in effect in the period 1995 to 1999, were not substantial by comparison to the industry's own actions.

Although these rate reduction actions were unwarranted in light of the subsequent loss ratios and insolvencies, the impact on the loss ratios was not that significant when considering the magnitude of those loss ratios even after undoing the damage from these changes.

The major concern is that of perception in the marketplace. A viable insurance market is not assisted by the perception that the CDI has a proclivity to intervene in the rate-setting process and, thereby, has signaled the adoption of the position that free market forces will not be allowed to function.

Ratemaking and Pricing Environment



At times, these actions serve as support for a watchdog consumer protection role that is valuable in personal lines, but is unique for workers' compensation among commercial lines. These actions can have a negative impact on a healthy competitive market if done frequently and without substantiation.

Although the deregulated model can and will correct itself over time, there are painful side effects of this market correction. Availability, prices and timely, adequate benefit delivery to employees have suffered because of the crisis and the delay in fixing the system. Regulatory oversight, as well as earlier warning from the WCIRB, could have helped to stem the crisis before it reached such epic proportions.

We have seen examples of companies file for and use rates that are below the recommended WCIRB advisory pure premium rates. The filing and use of rates, should be more adequately justified prior to approval and use by carriers in California. Any rate below, for instance, a 125% level of the advisory pure premium rates should require justification.

Recommendation #1– Level A

CDI should take a more proactive role in requesting justification for scheduled rate credits and their approval.

Scheduled credits (and debits) are modifications to the otherwise applicable rate, supposedly based on a review of various safety programs in use by the employer. In reality, they have proven to be merely a competitive pricing tool. Their use is not considered by the underwriting community to be the means of pricing accurately, but is considered to be nothing more than a competitive tool, used to lower prices below cost.

The use of a system of pricing by occupation, the classification system, and the process of developing a rate that reflects individual employer experience, the experience modification program, are sufficient vehicles for maintaining equitable rates within the system.

Given our analysis of advisory rates to-date, there has not been any danger of excessive rates being recommended or approved since the advent of open rating. The challenge to-date has been the ability of carriers to responsibly file and utilize adequate rates to support the cost structure of the system.

The danger of excessive rates being recommended by the WCIRB has not been encountered since the application of the open rating process in California.

Recommendation #2– Level A

Reduce or eliminate the use of all rate credits for the California market.

Dividend plans should be more widely adopted and utilized in lieu of scheduled credit rating plans. The dividends should be paid out of earned surplus; that is, the funds used for the dividends must be shown to have been profits gained from writing the business that will receive the dividend.

As a result, rather than being used merely as a marketing tool to insureds, rate credits will serve as a means of developing equity in the pricing process. With the additional justifications for scheduled credits, that we have recommended, back-end dividend plans based on the experience of the employers and carriers may be a more tenable and perhaps preferable loss-sensitive pricing mechanism and model for employers.

Employers should be rewarded for good claims experience, and alternatively, should bear the costs for higher-than-average losses. Dividend and loss-sensitive programs are excellent mechanisms for doing so.

Rate Adequacy Standard

In light of the need to attract adequately capitalized insurers to the California workers' compensation market, it is fair to review the question of whether the CDI should move towards a "rate adequacy" standard. Rate adequacy standard is a system by which CDI would require the use of rates that would not tend to impair the solidity of the company charging them. It also raises the question as to whether such a standard would be effective in preventing or slowing insurance companies' insolvencies.

The "problem" with the workers' compensation *system*, rather than the insurance mechanism, is one of high cost rather than poor predictability. The system costs are moving upward in a somewhat predictable manner. The unpredictable portion of the insurance equation has been the setting of prices by the industry in relation to the discerned costs.

California's system has become one of, if not the, most expensive systems in the country. Meanwhile, the insurance mechanism has been unable to deal with its own pricing problems and has generated a plethora of under-priced insurance. This has led to insolvency and a level of competition that have created a competitive environment which, despite its current moderation in advisory rate strengthening, has precluded new entrants from entering the market.

We believe that additional carriers and capacity will be attracted to the California market only if pricing freedom is retained. Classical economic theory maintains that a healthy market is one where the participants are free to succeed and free to fail, the latter being the more important of the two.

The 1992 California Rate Commission Study cited earlier testimony and reports from the Justice Department in 1977, "Workers' Compensation appears to be one line of insurance which is perhaps most conducive to *total* state deregulation and full exposure to market controls; there is *relatively greater predictability and stability in the industry*, there is potential for *vigorous price competition* and there are economic incentives to employ loss controls." (Emphasis added.)

Clearly, many other jurisdictions have found that a system that allows the marketplace to set rates is by far the most superior form of rate regulation. In the case of moving from the minimum rate law to "open rating" in California, the problem that surfaced was not price regulation, but solvency regulation.

Despite the problems associated with insurer insolvency, the consumer benefited dramatically from competition, and the system should be further unbridled to ensure that the competitive marketplace would keep prices as low as possible. This can only be accomplished by the relinquishing of the current intervention in the marketplace by the CDI in the approval of the pure premium process.

Recommendation #3– Level A

California may wish to review reducing the rate oversight and approval mechanisms and procedures at CDI.

There may be a reduced need for the CDI to approve the pure premium, or starting point for the rates. From past actions, the CDI has shown that it is willing to interfere in the marketplace. This is not conducive to encouraging a strong marketplace.

We reiterate that Insurance Commissioners across the country regularly reduce or eliminate the recommended rate increases for political expediency. Often, these actions support a watchdog consumer protection role that is valuable in personal lines, but is unique and unnecessary for workers' compensation among commercial lines.

WCIRB does an adequate job of creating the advisory rates. This process, along with the fact that public members serve on the WCIRB board, opens the process to public oversight.

Recommendation #4– Level A

CDI regulatory emphasis should be placed on solvency regulation. That emphasis should be on the liquidity aspects of an insurer. Also see Recommendation #12.

This can be accomplished by instituting asset and liability matching criteria analysis to be enacted by CDI. We do not have the time and resources to create such a tool under the

scope of this current study. We do recommend that CDI, and NAIC look to existing RBC measures to measure the liquidity of assets more closely.

The NAIC has been strengthening solvency regulation since the early 1990's. Among other things, it adopted risk-based capital (RBC) standards for the property/casualty industry to take effect for the 1994 annual financial reports filed with regulators in March 1995. RBC standards replaced individual state surplus and capital requirements, which varied widely from state to state and had been frequently criticized as being too low and too simplistic to be meaningful thresholds for capital adequacy. In some states, a large insurer could have been insolvent while still meeting the minimum requirements.

The old blanket minimum requirements were replaced with standards geared to the specific characteristics of the company and its business, a move designed to improve solvency regulation. With formulas that reflect individual capital needs, examiners can more quickly identify insurers that are under financial pressure and take action earlier to avert insolvency.

The adequacy of a company's capital is assessed by comparing its total adjusted capital, which is basically its net worth, with its RBC — an amount of capital that reflects the level of risk the company has assumed. Currently, risk measurements are in four major categories: asset risk, a measure of an asset's fluctuation, credit risk, a measure of default on amounts due, underwriting risk, a measure of the potential deficiency in reserves and pricing; and off-balance-sheet risk, a measure of other forces, such as excessive rates of growth.

The greater the total riskiness, the greater the minimum financial cushion must be. The result is expressed as the company's RBC ratio. Ratios are categorized in six levels or zones that run from adequate (125 percent and higher) to mandatory control or below 35 percent, at which point the insurance commissioner is authorized to seize the company unless there is some reasonable expectation that the circumstances that caused the depletion of capital will be remedied within 90 days.

The inadequacy of such a system is that it is not sufficiently dynamic. Solvency regulation must measure the anticipated actions that will take place in the future predicated on conditions that have already been put in place by actions of the insurer. For instance, loss reserves will be paid out according to estimable patterns. Correspondingly, certain assets will be maturing in a predictable manner. Those two elements should be sufficiently predictable, and the matching amounts have safety margins large enough to ensure not just solvency, but solidity.

The Role of the Rating Bureau and Recommendations

By all accounts, unbridled competition led to unsound underwriting, reserving and claims practices from carriers who, in a rush to price their product competitively, ignored fundamental operations that are required for sound underwriting. These actions also

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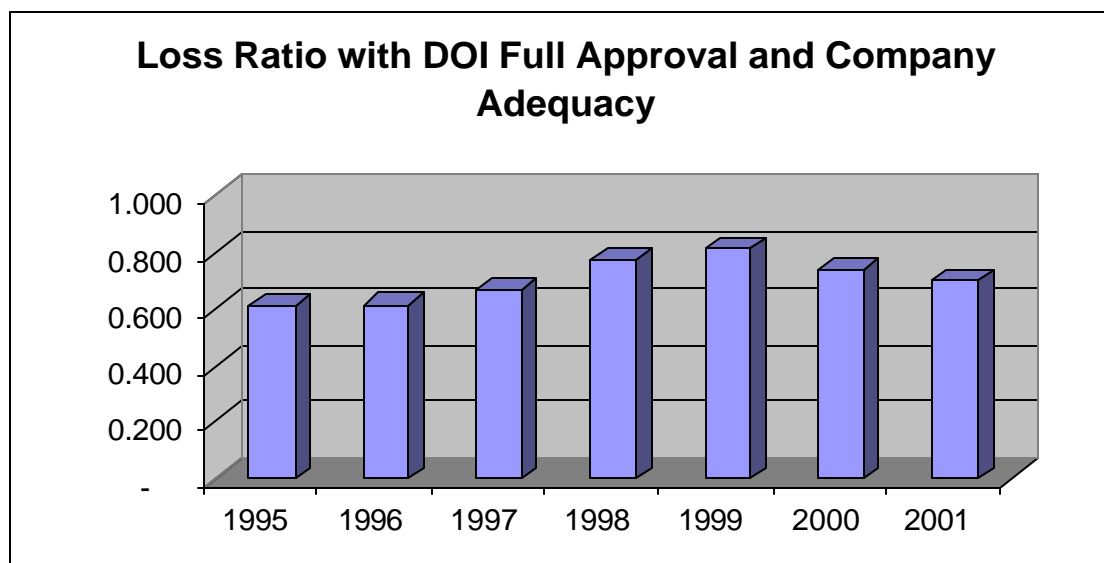


permeated the self-insurer market. Increasing insolvencies have been exacerbated by inadequate security guarantees for self-insured liabilities.

Analysis shows that WCIRB was publishing adequate, but not excessive advisory rates. Again, as we show elsewhere in the report, carriers in the market need to more adequately apply those advisory rates with realistic pricing factors. WCIRB is in the best position to gather, analyze and recommend rates. Their adjustments in the past few years have made rate filings even more adequate for advisory filings.

Chart 13 shows the loss ratios that would have resulted if the insurers filed sufficient expense and profit loadings and the Department of Insurance had not reduced WCIRB's indications. The problems associated with the 1998 and 1999 loss ratios reflect loss - reserving practice changes, which have now been more fully estimated. Other states have shown as much or more variation in loss ratios in this same period.

Chart 13



As we reviewed the process earlier, ratemaking is a two-step process, the overall level, based on insurance company summary data, and classification indications, which are based on individual employer data.

To increase the utility of rate filings, WCIRB should:

Recommendation #5 – Level B

Make every attempt to continue gathering experience loss information from insureds that were with bankrupt carriers.

The classification system is based on a relationship established through an analysis of the data that is the foundation of the experience-rating plan, the unit statistical reports. Every attempt should be made to protect the integrity of that database so that experience modifications will be available for all employers.

Recommendation #6– Level B

The California Legislature should consider expanding the ability of WCIRB to explore collection and utilization of self-insured and public employer loss data to more fully capture the loss experience of the entire California marketplace.

WCIRB is responsible for the creation of the pure advisory premiums for the California workers' compensation marketplace. They are the data services and repository organization for loss-cost information. With the adoption of this recommendation, utilization of self-insured and group self-insured loss information for the establishment of the classifications currently outside the available rate setting mechanism will be open to the system.

We believe WCIRB is best able to look at the entire market experience and most responsibly and objectively create classification relativities that will result in reliable risk information for all employers. Self-insurers will also benefit from this change, as they can create more accurate internal rates if they include loss experience from the entire population of a class code.

As there is a push to more self-insured groups in California, similar-sized businesses will be taking themselves out of the loss pool. Expanding the pools of data collection as pools make up more of the market mix will help to make the ratemaking system more accurate for the entire system.

Inadequate Loss Reserving

In subsequent sections, we address classification ratemaking, geographical implications and size of risk differences. The more important ratemaking area that has been problematic, loss reserve inadequacy, has been the most difficult for WCIRB to deal with.

Recent insolvencies have been under-reserved by as much as 45% according to the regulators and industry participants we interviewed. One-half to three-quarters of all self-insured cases taken over by SIP were under-reserved, thus adding to the inadequate security position.

Actuaries, in developing estimates of ultimate losses and resulting rate indications, depend on historical movement of losses as they age. Losses from a particular accident year will change as those losses age and reach their final payout. If historic patterns become erratic, forecasting future losses can be a problem. California has been subject to some aberrations in this regard. Reserving practices have changed, creating a situation where historic patterns have not reflected the most recent activity and, accordingly, are not reflective of what is expected to happen to losses in the future.

As a result of this condition, WCIRB has incorporated significant additional loss reserve adequacy measurements and adopted more responsive loss reserve techniques. This has been accomplished through a greater dependence on the more recent paid loss activity and a lessening of the dependence on the stated reserves. In our estimate, the steps taken should resolve the problem and will strengthen the ratemaking system in the future.

Additional Ratemaking Considerations

The Effect of Deregulation on Employers

Having established that WCIRB rates overall are not the cause of the disastrous results and that the insurance industry itself is the cause of rate inadequacies, it is appropriate to ask the following question:

Does unfair discrimination exist based on size of risk, type of industry or location of insured?

According to the classical definition, an important aspect of regulation is to foster adequate, but not excessive rates that do not unfairly discriminate. One of the more frequently asked questions is:

“Did deregulation result in unfair rates by size of insured?”

Other questions that we reviewed centered on the following areas:

“Does deregulation hurt certain-sized employers, certain industries, or certain regions more than others?”

In order to answer that question, we reviewed data by size of risk, location and class to ascertain the equity of pricing after deregulation.

Although this particular question, in light of the overall inadequacy of the applied rates, is less relevant than it would be in a rating environment that was not so clearly inadequate, it is an important issue. When the overall system is systemically under-priced, causing total domestic company failure and market abandonment, the question becomes:

Were some segments of the market more, or less, as the question is phrased here, under-priced than other segments?

All types of insureds were mispriced. We found that the mispricing was not unfairly discriminatory and the benefit, although temporary, was uniform. We analyzed:

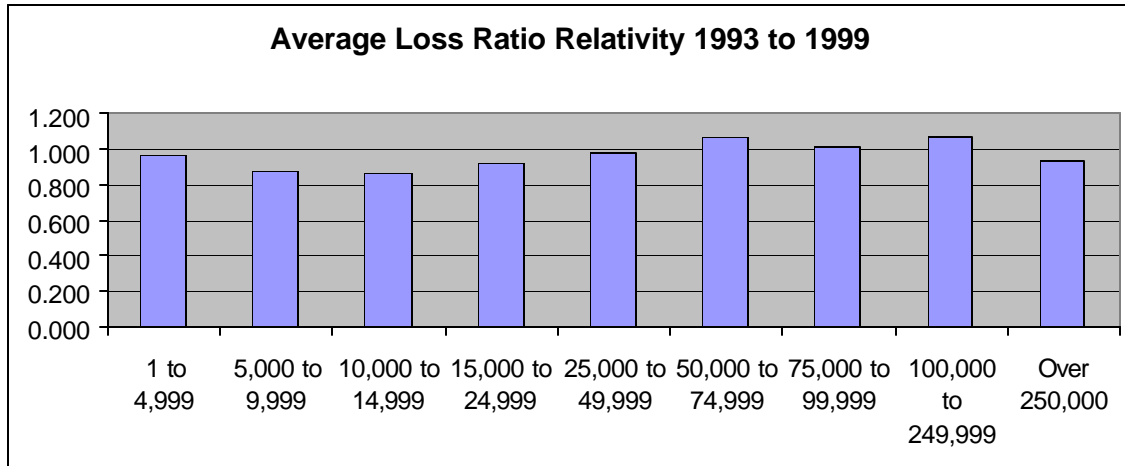
1. Loss ratios by size of risk.
2. Pure premium worksheets by class.
3. A review of indications by ZIP Code, which was also done by size under the theory that the smaller risks will be more closely reflective of their main locations ZIP Code.

Results of Analysis of Loss Ratio by Size of Risk

Our analysis showed that there is minimal unfair discrimination by size of risk. The only risks that appear to have earned premium disproportionate to their exposure are the risks from \$5,000 to \$25,000. One explanation for this phenomenon is that smaller-sized employers may have more manageable safety programs in place, which may decrease the severity and length of lost time claims. Other theories hold that there may be more under-reporting of injuries for smaller-sized employers.

Chart 14 shows the historical loss ratio relativities as reported to the WCIRB in the unit statistical reports covering policies issued in the period 1993 through 1999.

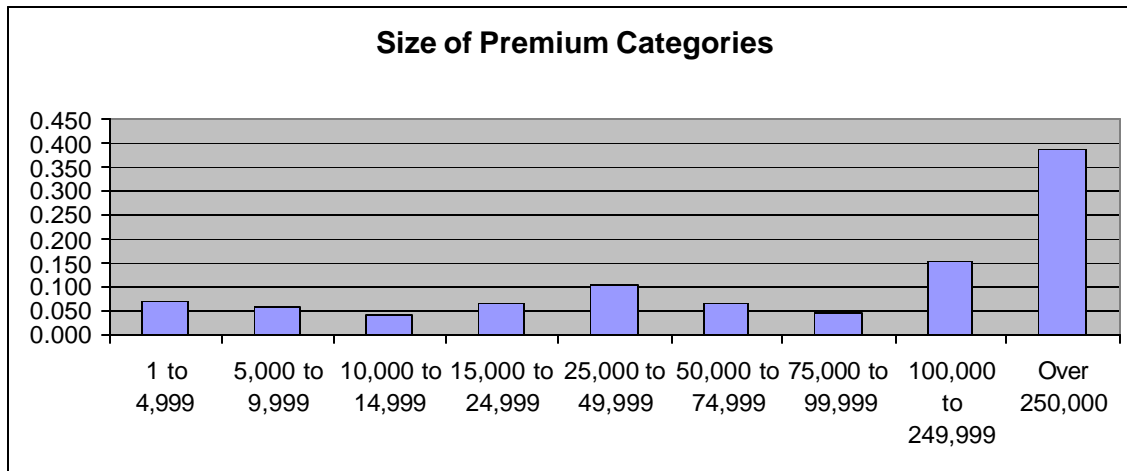
Chart 14



Source: WCIRB

The predominant premium volume is, as can be expected, in the risks over \$250,000, which have loss ratios slightly lower than the average.

Chart 15



Source: WCIRB

The Appropriateness of Classification Rates

We analyzed the classification ratemaking process to determine if rate development at the classification level resulted in fairly priced policies.

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As is standard actuarial ratemaking practice for workers' compensation, the California system separates employers on the basis of work performed, classifying workers into 458 classifications. A typical classification is 8810 representing clerical workers. For example, classification codes 8110 and 9079 are two relatively high workers' compensation rates measured per hundred dollars of payroll. Two of the lowest code rates in California are Class 4691 and Class 8810.

In our analysis of this question, we focused on three groups of classifications:

1. Those with higher-than-average credibility, that is, the larger classification groups.
2. Those of average credibility.
3. Those of smaller-than-average credibility size.

We selected these groups because one of the sources of unfair discrimination could be the handling of indications developed from the historical classification of the data. Each of these groups has a somewhat different handling of the data.

Because large amounts of data can be more stable predictors of the future, the classifications with the largest amounts of data have their data used to a greater extent than classifications with smaller amounts of data.

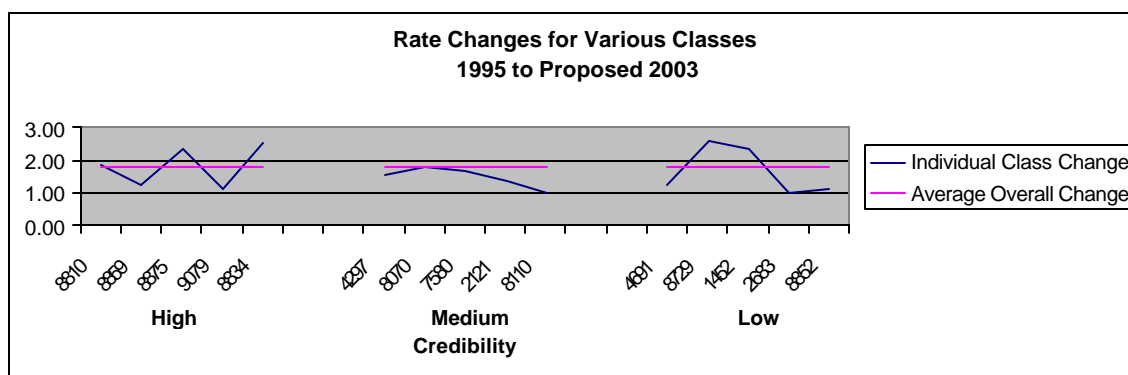
As a result, it is appropriate to ask the question,

“Is the data treatment by class appropriate?”

In other words, are the resulting indications, which generate the rates to be charged, appropriate? Do they result in a fair discrimination by class?

In addressing this question, we reviewed the three groups of data and analyzed the experience for each. Our conclusion is that the classification system handles data appropriately. The results show no bias among the classifications.

Chart 16



More variation will be seen among the smaller classes due to their sample size and absence of full credibility. Class 8852, which has only a 13% credibility, is indicative of such small classes that are more dependent on the indications from their group.

After our review, we have concluded that the classification ratemaking system, as implemented by the WCIRB, results in equitable classification rates. WCIRB, however, should undertake a review of the smaller classification ratemaking process to appropriately modify the system so that disruptive increases can be tempered without losing equity in the process.

Pricing by Geographical Location

Nationally, workers' compensation pricing is not geographically sensitive on an intra-state basis. The major reason for introducing geographically based rates would be to reflect geographic cost differences. Rates are based on payroll, which means that regions with higher average salaries will automatically generate additional premium. However, the resulting premium differences may not compensate sufficiently for the differences in loss frequency and the cost of a claim.

The first step in our approach was to analyze the effect of the exposure differences by area. The variation of these exposure or risk differences can be measured by comparing the ratio of losses to payroll by area. Since this ratio reflects the difference in risk by area, that relationship will serve as the measure for the "riskiness" of each area.

Since the pricing mechanism in place attempts to evaluate the "riskiness" of each grouping of payroll by type of industry, we will be able to quantify how well the pricing mechanism accounts for this riskiness by area. The pricing system accomplishes this by attaching a different price to each classification. As a result, in this first step, we will have some measure of the exposure variation by region.

The second step is to measure whether the pricing system in place adequately reflects those exposure differences. If the system were working perfectly, we would have the same or equal loss ratios for each region. In summary, the loss-to-payroll ratio will give us an indication as to the differences in exposure by region, while the loss ratios by region will allow us to judge how well the pricing system accounts for those differences.

Because data is not collected by area for individual losses and premium, but are coded to the location of the corporate headquarters, we were limited in our selection of data. We analyzed smaller risks by zip code.

We did this with the assumption that the corporate headquarters for smaller risks more closely paralleled the distribution of employees than a large risk would with a higher probability of multiple locations with a disparate geographical makeup. A review of the

Ratemaking and Pricing Environment

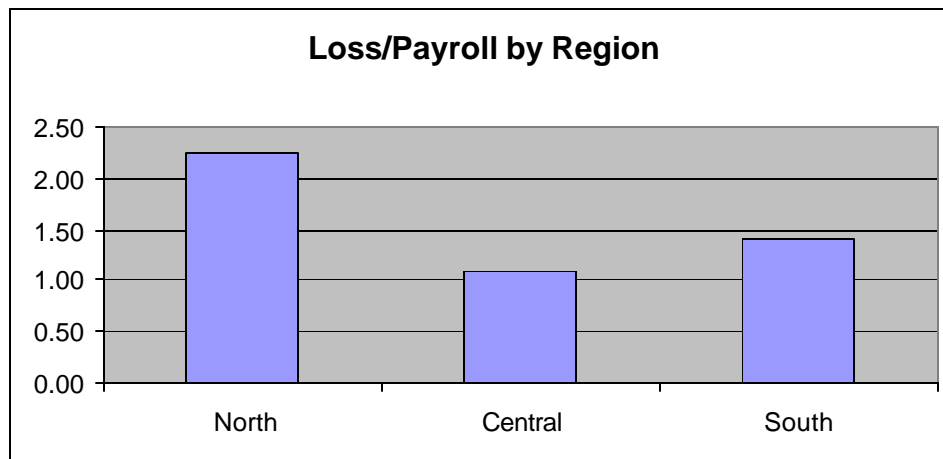


data separated into smaller versus larger risks, however, did not show a significant difference in result.

The definitions of areas and the distribution of zip codes into regions are detailed in Appendix #2.

The largest losses per payroll unit was produced in the Northern California area with Central California markedly lower, while the South was somewhere between the two.

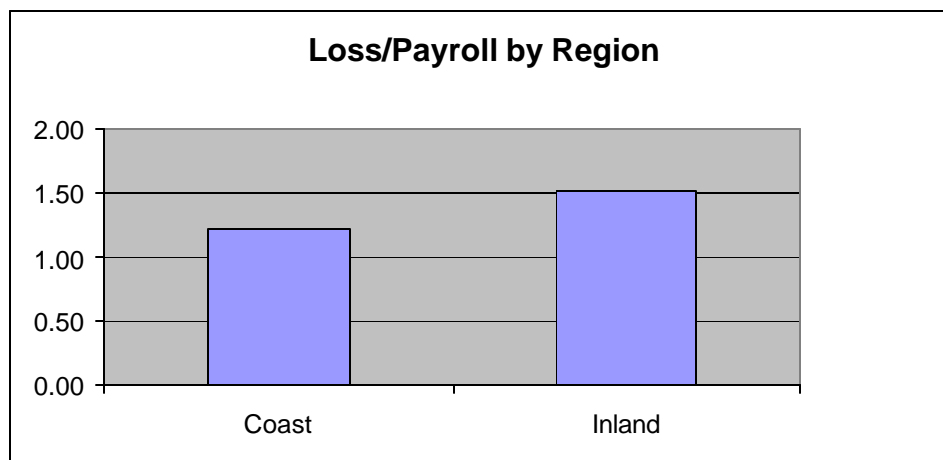
Chart 17



Source: WCIRB Unit Stat Reports 1993 – 1999. Losses are per hundred dollars of payroll and based on raw data from WCIRB’s unit statistical plan.

A breakdown by Coast and Inland shows the Inland “riskiness” per payroll dollar to be greater than the Coast.

Chart 18



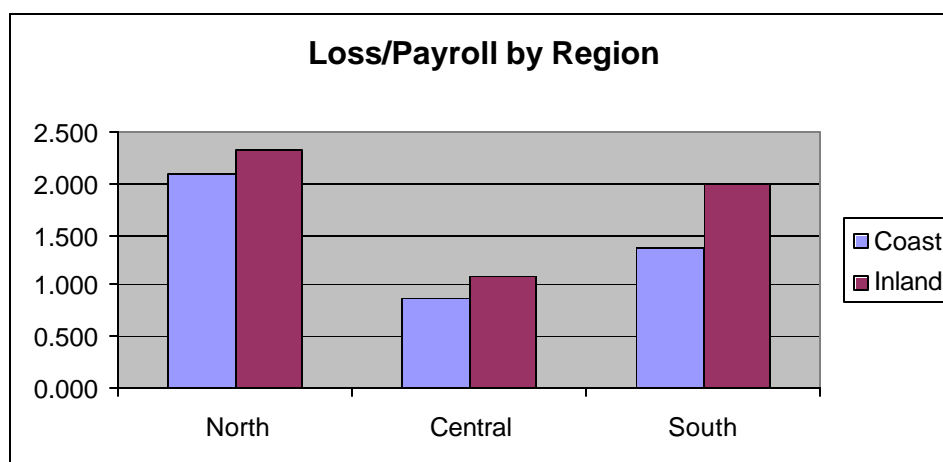
Source: WCIRB Unit Stat Reports 1993 – 1999. Losses are per hundred dollars of payroll and based on raw data from WCIRB’s unit statistical plan

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A combination of the two breakdowns shows that the North for both Coast and Inland are the highest loss-producing areas per dollar of payroll while Central is the lowest. Within each of the regions, Inland produces more losses than Coast per dollar of payroll.

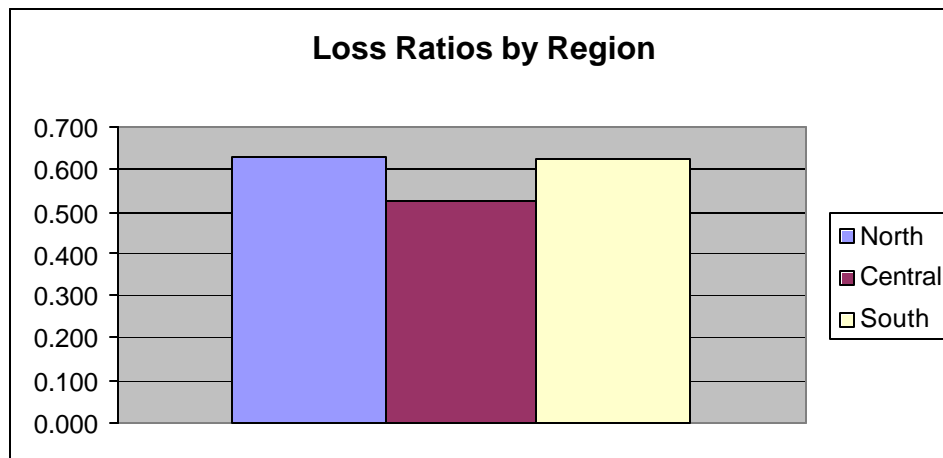
Chart 19



Source: WCIRB Unit Stat Reports 1993 – 1999. Losses are per hundred dollars of payroll and based on raw data from WCIRB's unit statistical plan.

Much of the difference in "hazardness" is mitigated when we review the loss ratios. Although Central is somewhat lower the North and South, Chart 16 shows conclusively that the pricing mechanism establishes equity between two of the regions and does so partially in the Central region.

Chart 20

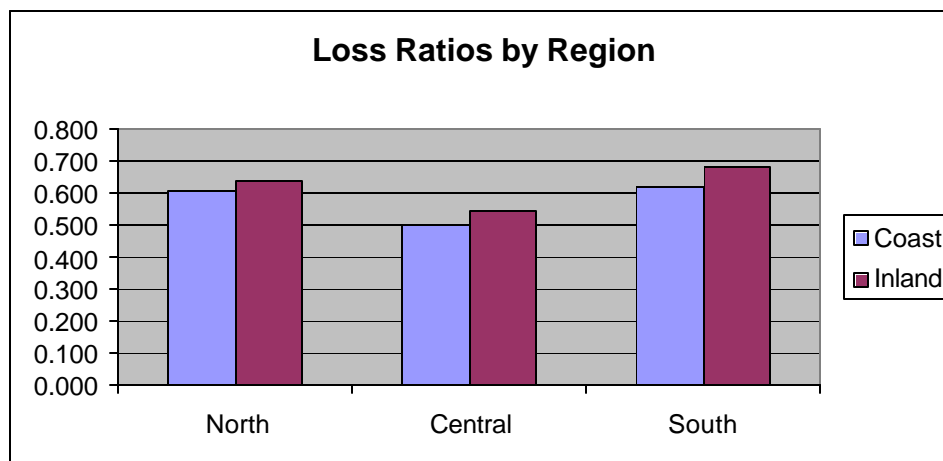


Source: WCIRB Unit Stat Reports 1993 – 1999

The loss ratios, when broken down by Coast and Inland, show the same tendencies but not as pronounced as the loss to payroll relationships. Although a perfect pricing mechanism would have resulted in the same loss ratios for all areas.

It is our conclusion that the small bias against the Central and Inland portions of the state is not significant enough to warrant a recommendation for changes to the class code ratemaking process.

Chart 21



Source: WCIRB Unit Stat Reports 1993 – 1999

Ratemaking and Pricing Environment



Based on our analysis, we believe that recommendations at this time are appropriate or warranted for introducing mandated geographically sensitive rates.

The apparent cost differences by area are to some degree entering into the pricing of workers' compensation, which is evidenced by the tempering of loss ratios by area from the more differentiated loss-to-payroll ratios.

Schedule credits (and debits) are a modification to the otherwise applicable rate, supposedly based on a review of various safety programs in use by the employer. In reality, they have proven to be merely a competitive pricing tool. Their use is dismissed in the underwriting community as a means used most often to modify the pricing of a product downward.

The use of a system of pricing by occupation, the classification system, and the process of developing a rate that reflects individual employer experience, or the experience modification program, are sufficient vehicles for maintaining equitable rates within the system.

In addition, companies are filing for and using rates that are below the recommended WCIRB advisory pure premium rates, which are designed to cover only the benefit portion of the rate and do not include provisions for either expense or profit.

The filing and use of rates should be more adequately justified prior to approval, and utilization by California carriers. For example, any rate below a 125% level of the advisory pure premium rates should require full justification.

This recommendation supports the basic focus of recently introduced legislation, which requires the Commissioner to approve only those discounts and credits that are fully justified by the carrier. The Insurance Department in Missouri instituted a similar requirement in 1997, allowing scheduled credits beyond 50% (sliding to 25% by 2000) of premium only when certain procedures were met.

Given our analysis of advisory rates to-date, there has not been any danger of excessive rates being recommended nor approved since the advent of open rating. The challenge to-date has been the ability of carriers to responsibly file and utilize adequate rates to support the cost structure of the system.

The danger of excessive rates being recommended by the WCIRB has not been encountered since the application of the open rating process in California. Michigan and Illinois do not allow deviations from the advisory rate filings. Michigan is an independent bureau state while Illinois utilizes NCCI ratemaking services.

Interestingly, there have been no mathematical models justifying scheduled credits as a rational discount strategy. With class codes and effective experience modifications in

Ratemaking and Pricing Environment



place, the California market should already have the most effective method for measuring the true loss profile of an insured.

As a result, rather than being used merely as a marketing tool to insureds, the method will serve as a means of developing equity in the pricing process. With the additional justifications for scheduled credits we have recommended, back-end dividend plans based on the experience of the employers and carriers may be a more tenable and perhaps preferable loss-sensitive pricing mechanism and model for employers.

Employers should be rewarded for good claims experience and, alternatively, bear the costs for higher-than-average losses. Dividend and loss-sensitive programs are excellent mechanisms for doing so.

California System Cost Drivers

A. Medical

To improve the system predictability and cost controls that are necessary to attract carriers who must put their surplus at risk when writing additional premium in California, the system needs to become more predictable in costs and outcomes. Later in this report, we will discuss in more detail later in the report how this can be accomplished through implementing some changes in the following general areas:

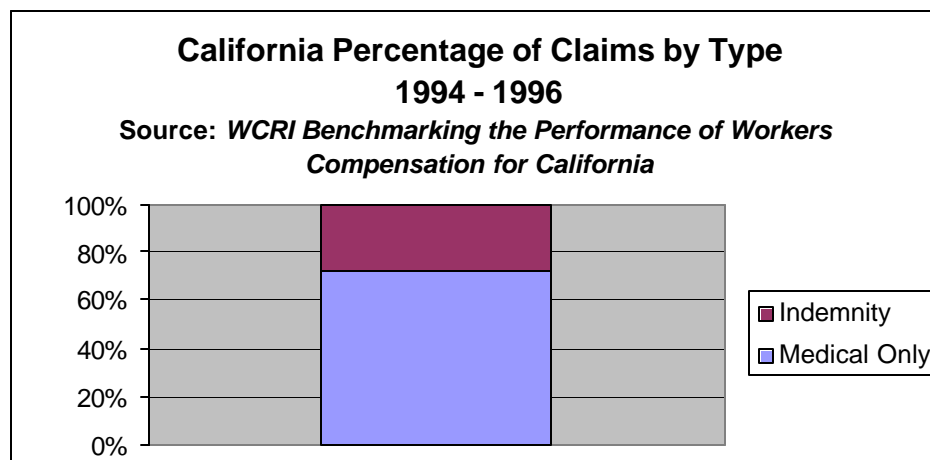
- Fee schedules.
- Treatment parameters and protocol.
- PD schedule revision and consistent application.

Severity

While California has benefited from the decrease in claim frequency that has been evident throughout the country, California claim severity in the form of higher medical and indemnity costs per occurrence has escalated. This follows a pattern that exists throughout the country. However, it accentuates a problem that has existed in California for some time: the higher cost of a California workers' compensation claim.

In analyzing the forces at work, it is necessary to separate the system's two major elements, the medical and the indemnity portions of the system. The majority of claims are of the medical-only type. However, the majority of total California system costs are driven by claims that have both medical and lost-time or indemnity payments.

Chart 22



California System Cost Drivers

A. Medical

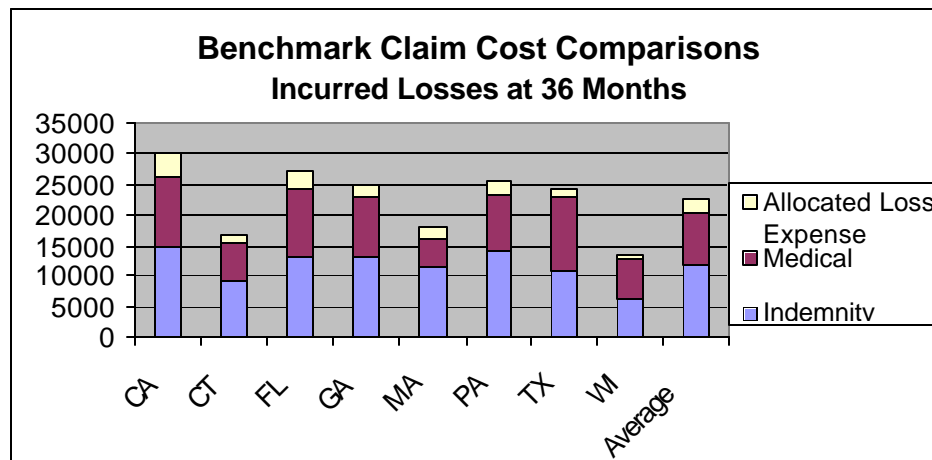


When California's costs are compared to other states' costs, a pattern emerges that shows that California has considerably higher costs than most states and certainly higher than the average. This is true for both the medical and indemnity portion of claims. The explanation for this is not simply that each individual type of claim costs more. It is the mix of lost-time claims that explains much of the cost differences.

The overall picture is shown below. In its August 2001 study, the WCRI reviewed the indemnity, medical and delivery costs of eight states including California. The purpose of this chart is to show the comparative costs of California versus other states, including some high-cost states. The average consists of all costs for the eight states involved. (The values are from WCIRB's database and are incurred losses valued as of 36 months.)

To ensure a comparison of similar occurrences, the data is for claims that exceed seven days of lost time. As a result, the values are for comparative purposes only. California had the highest average indemnity; only Texas had higher medical incurred cost. The delivery of benefit expense in California was the highest, 84% higher than the average. The total claim cost was 32% higher than the average of these particular states.

Chart 23



Source: WCRI CompScope *Benchmarks: Multistate Comparisons, 1994 - 1999*

However, if we isolate a single type of claim, medical-only, we are able to analyze the medical cost portion and draw some conclusions concerning medical expense that are not influenced by the indemnity provisions and the system's influence on inflating costs.

The following chart shows the average values by state for the medical-only claims. (Claims are grouped for statistical analysis purposes into five categories: Death, Permanent Total, Permanent Partial, Temporary Total, and Medical Only.)

The medical-only claims are those where there are no indemnity payments for lost time or permanent disability (thus only medical payments.) Of the 17 states with the same waiting period, California was the third highest in both the 1993 and 2003 Statistical

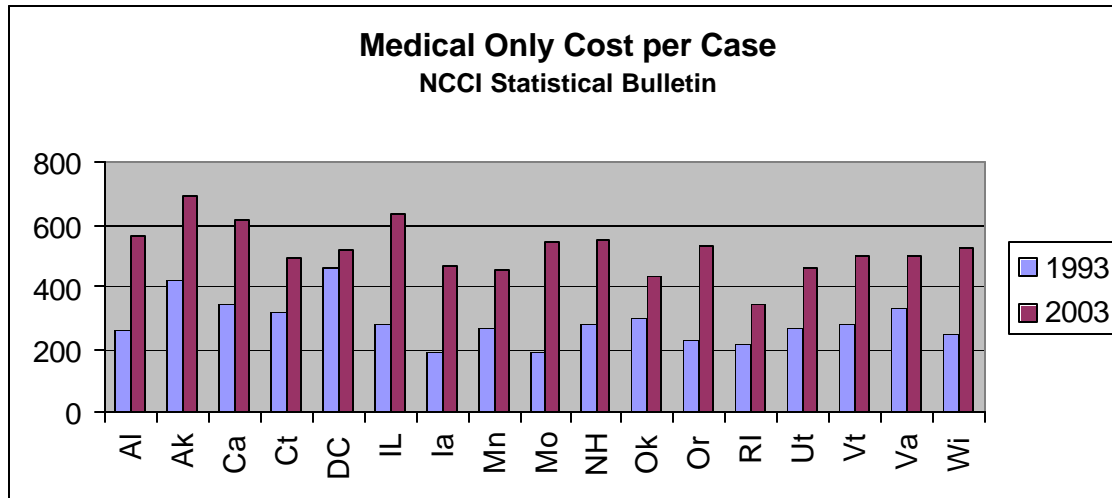
California System Cost Drivers



A. Medical

Bulletins. In the 1993 statistics, California costs were 19.5% higher than the average of the listed states, while in 2003, costs were 18.4% higher.

Chart 24



Although medical costs have increased dramatically in the period under review, other states in the group of 17 have seen even more dramatic increases.

Chart 25

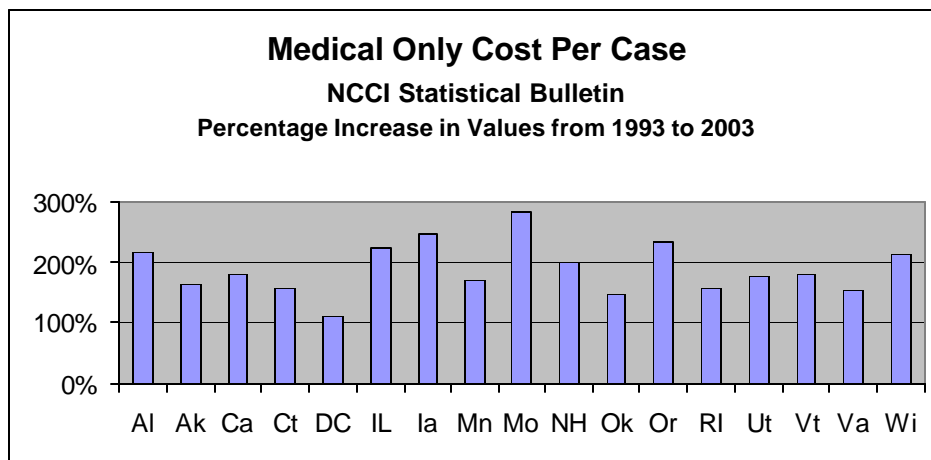
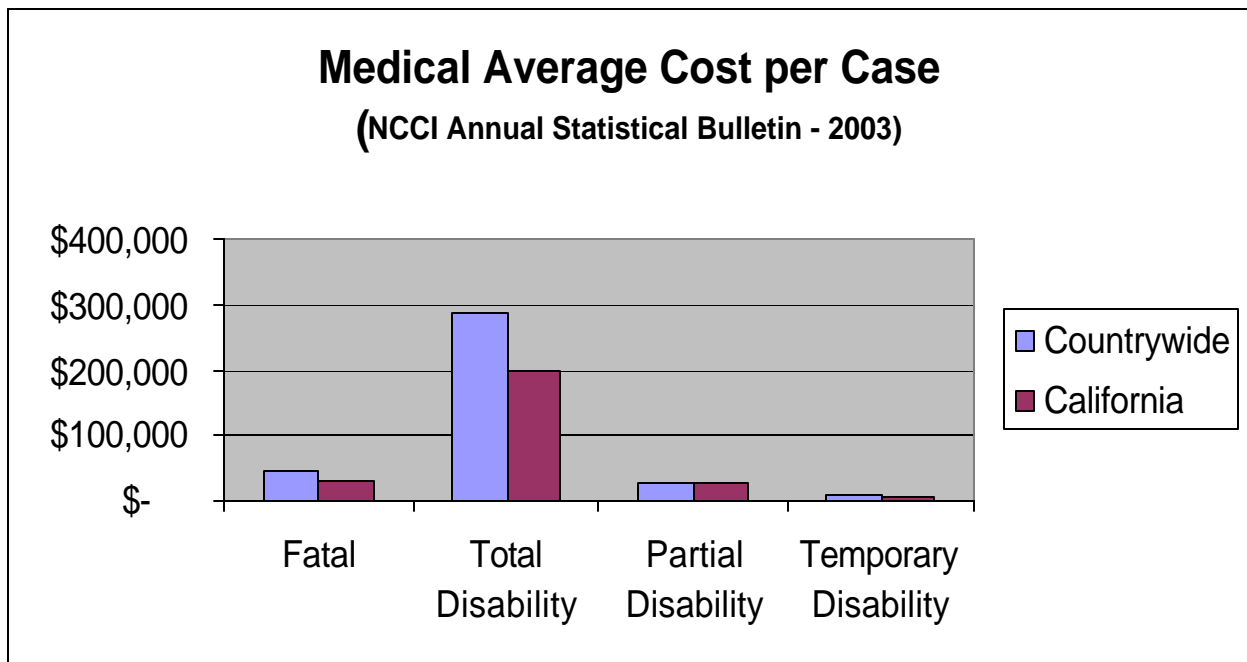


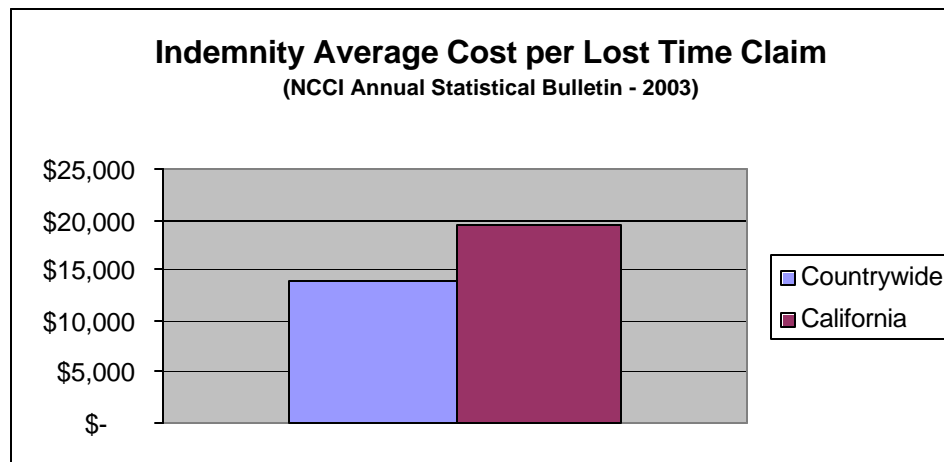
Chart 26



The comparison of the medical portion of other types of claims shows a rather optimistic picture of the California system. California medical cost by the various types of injury is consistently lower than the national average. It would appear that the medical cost per type of case is not the sole driver of the total cost of workers' compensation in California.

As a direct result of the predominance of permanent partial cases, the average indemnity cost per case in California exceeds the national average by a significant amount, \$5,665. The indemnity portion of a lost-time case in California was \$19,489 versus \$13,824 countrywide.

Chart 27

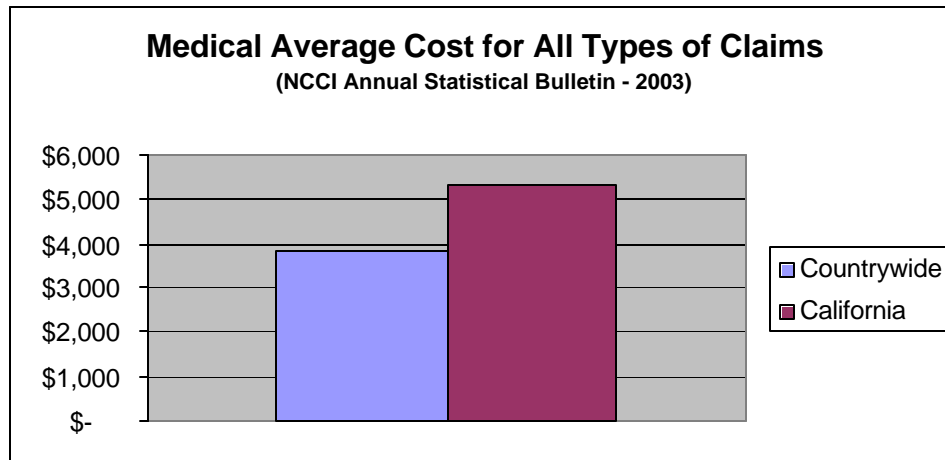


The average cost of the medical portion of the permanent partial cases shows the results of the predominance of cost generated by the permanent partial disability cases. Because permanent partial disability cases have significantly higher costs than other types of cases, the resulting average value for states that have higher-than-average percentages of these cases has higher-than-average value costs per case. California has by far the highest percentages of permanent partial cases and, as a result, suffers from the highest costs⁴.

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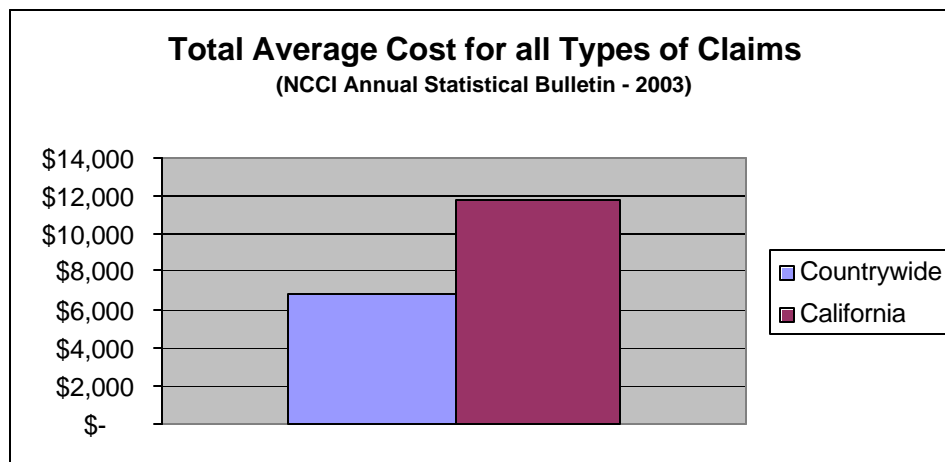
As an example of this situation, assume that States A and B have only two types of claims Permanent Partials and Temporary Totals. Assume that the costs for State A claims are \$100,000 for PP and \$5,000 for TT and for State B \$50,000 and \$2,500 respectively: that is, State B's claims by type are 50% less expensive. If State B has 90% of its claims in PP, the average value of its total claims, 90% PP and 10% TT, would be \$45,250. If State A had 30% PP and 70% TT, it would have an average value of \$33,500. As you can see, even though State B had higher average values by type, because it had more of the higher-cost claims, its overall average costs were lower. California's P\permanent partial claims are only 12% higher than the countrywide average, while its overall average claim is 73% higher than the countrywide average because of the predominance of permanent partial cases.

Chart 28



The combined average cost, medical and indemnity together, shows the problem clearly. Because of its predominance of permanent partial disability cases it has a significantly, and disturbingly higher average cost per case.

Chart 29



All cases: The California overall cost per claim for all types of claims was \$11,788. The countrywide average was \$6,830.

Other Incentives and Recommendations

Cost Controls

“Medical costs are increasing rapidly as we all know. Clearly, this is the most significant cost-driver, as such costs escalate at around 13% a year. In the case of workers’ compensation evaluation and documentation costs are rapidly rising and little discipline appears to occur. Medical cost increases show no sign of abating, and it is a problem affecting overall healthcare nationwide.”

This comment – from the 1992 Rate Oversight study – holds true today. In the ensuing decade, no effective medical cost-control mechanisms have been adopted in California. Until those costs are addressed through a comprehensive fee schedule and treatment protocol system, we believe there is little hope for costs to abate in the next five (let alone ten) years.

Medical costs continue to be the major cost-driver for the California workers’ compensation market. Estimates from the WCIRB indicate that medical benefit inflation has increased an average of 12% annually since 1994. National inflation rates as recently measured by NCCI show annual medical inflation also at the 12% annual rate. WCRI measured national trends for workers’ compensation medical costs as growing at an annualized rate of 7.5%.

The challenge is that California has a much different frequency and development of medical costs associated with PD cases, a problem discussed elsewhere in this report, as one of the main system cost-drivers.

In July 2003, the WCIRB reported that medical costs and services now comprise the majority (51%) of total loss payments in the California-insured market segment for calendar year 2002. This occurred as total medical costs increased 28% from \$3.2 billion to \$4.1 billion.

The Industrial Medical Commission (IMC) is a 20--member board that serves as the advisory group to the Administrative Director of the DWC. The IMC is in the process of studying and recommending medical cost-control tools such as fee schedules and treatment parameters. With medical expenses continuing to drive system costs, we believe more immediate action needs to be taken.

AB 749 gave the Administrative Director of DWC the authority to study and implement a meaningful outpatient and pharmacological fee schedule. Unfortunately, the legislation also requires the DWC to consider one year’s worth of data from the OSHPA studies and reports that are currently unavailable and may not be entirely germane to the occupational medicine treatment that is most commonly required for workers’ compensation injuries.

A more timely method is to utilize currently available California data from other sources, take a look at the data, make a declaration that the Administrative Director has reviewed the information, and adopt another state’s fee schedule outright on an emergency basis.

California System Cost Drivers

A. Medical



Adjustments to the reimbursement rates unique to California may be studied and implemented at the end of a three-year analysis period.

Some of the other state fee schedules already have the advantage of being tied to a multiplier of Medicare and still offer a significant reimbursement premium to the providers over Medicare.

Recommendation #7– Level A

Immediately adopt fee schedules for all treatment segments to a 100 or 120% level of Medicare. This may be a reasonable place to start. CHSWC has already done background work to identify this as an effective method to control medical costs

Valid reasons for adopting a medical fee schedule tied to the Medicare schedule are:

- Shifts the burden for updating and monitoring the multiplier to the federal government and reduces the administrative burden on the DIR.
- The Medicare fee schedule billing mechanism depends on utilizing the already familiar billing forms (HCFA and UB92.) Most providers are very familiar with these, and a transition should not be difficult.
- The Medicare fee schedule covers all providers, even surgical and outpatient services.
- The payment level is tied directly to resources required.
- The Medicare fee schedule already takes into account regional differences inherent in overhead charge arguments used by providers to justify higher outlier reimbursement levels in the current California system.

These factors were identified in the CHSWC study “Adopting Medicare Fee Schedules: Considerations for the California Workers’ Compensation Program” by Barbara O Wynn at RAND.

Medical fee schedule language should be implemented similar to the AB 228 and should be applied immediately. CHSWC projected cost savings range from \$1 to \$4 billion immediately on reserve reductions, with ultimate annual savings of up to \$1.8 billion.

Projected savings from fee schedule modifications and expansion to non-scheduled providers should be tempered by the possibility that discounts may have already been realized through volume or negotiated discounts between payors and providers.

Ultimate savings, however large, need to be tempered with the reality that if only one cost-control mechanism, such as a fee schedule, is implemented at this time, only 30% of

A. Medical

the estimated ultimate savings may be realized. This documented phenomenon, seen in multiple studies of the Medicare system shows that providers may increase overall numbers of and intensity of services to offset fee-schedule reimbursement rate reductions.

A fee schedule based on an Resource Based Relative Value Scale (RBRVS) model tied to the Medicare or Medical fee schedule is an important first step to control future medical cost inflation. We believe, it should not, however, be implemented in a vacuum. California should also implement complementary medical treatment parameters or protocols no later than 1-2 years after implementation of a medical fee schedule. The combination cost-control effects of a revised fee schedule and a treatment protocol guide will have a greater impact on controlling costs than implementing only one of the cost-control mechanisms.

Reimbursement restriction mechanisms are only one-half of an effective medical cost-control approach.

Utilization Control

Recommendation #8– Level A

Adopt meaningful treatment guidelines for all areas of the body. The IMC and DWC are currently exploring the feasibility of creating and implementing such guidelines on an acute phase.

These guidelines would be just that, guidelines which are refutable by the provider. Frequency limitations and a treatment plan to actually improve the injured workers condition or enhance a return-to-work are important elements of this recommendation.

The 1998 WCRI report *The Anatomy of Workers' Compensation Medical Costs and Utilization* provides some excellent insights into the medical utilization rates of California compared to 7 other states (Massachusetts, Connecticut, Florida, Georgia, Minnesota, Pennsylvania and Texas).

California averages nearly 70 services and 22 visits for each lost-time claim with more than seven days lost time. That utilization is 120% of the median state based on information from the eight states.

Medical treatment frequency and costs in California averages are significantly higher than the national average. The WCRI found that frequency of medical visits was two times higher than the national average, 31.2 visits per injury. The median treatment duration was 241 days, much more than any other state measured.

Although, on average, injured workers receive higher numbers of visits and treatments, that does not translate to an earlier return-to-work for those workers and their employers. In fact, over the past years, average length of time for wage loss replacement has increased along with the frequency of treatment.

California System Cost Drivers

A. Medical



Some would naturally conclude that as average severity increases for the fewer remaining overall injuries, it would be reasonably expected to see an associated increase in medical treatment utilization and length of disability.

In fact, these measures cited in the WCRI study were matched across state systems to help eliminate differences that could be caused by severity, waiting periods and injury mix. California is seeing an increase in medical utilization and costs that is being driven by those higher utilization rates across all lines of medical treatment. Unfortunately, California workers and employers are not seeing a corresponding earlier return-to-work.

Combined with a much higher utilization and cost of medical cost-control services than other states, it is clear the current medical cost-control mechanisms available in the California system are working efficiently to provide quality care at an affordable rate and are not returning injured workers to employment sooner than expected.

Interestingly, studies (WCRI, Rhode Island and Texas Research and Oversight Council on Workers' Compensation (TROC) and the Medicare Payment Advisory Commission on Protocols) have not shown that access to care nor quality is adversely affected by implementation of fee or treatment parameters. Although treatment parameters and limits vary from soft to hard, they can be developed with reasonable clinical certainty for various medical conditions resulting from work injuries.

Other studies published by TROC have shown that higher medical costs are not correlated with higher claimant satisfaction of medical care. California should not be afraid to attempt to reign in medical costs, one of the major unpredictable cost driving components of workers' compensation, medical costs from all providers.

While this recommendation may face opposition, other states that have adopted these standards (Minnesota, Florida, Rhode Island and others) have not shown any decrease in access to or quality of treatment.

Whichever combination of cost-control mechanisms are adopted, resulting savings will likely last from three to four years before costs continue to increase at a more rapid rate as the system readjusts to a mix that continues the trend of long-term cost control and short-lived, but significant cost savings in costs after a change in reimbursement method.

The key to implementing an effective cost control structure is to:

Stabilize costs and control future growth in order to make the cost structure more predictable and dependable to reserve for. Increased accuracy on the medical cost-control side will lead to more adequate reserves, better indications to the WCIRB, and a better handle on future development of loss trends, which will in turn strengthen the accuracy and adequacy of advisory base rates.

California System Cost Drivers

A. Medical



Another cost--control method we recommend is to further explore cost savings from:

Recommendation #9– Level A

Require treatment plans be developed for injuries and require showing of cure AND relief from the treatment and that objective improvement is planned and progress is shown during approved treatment plans.

Rules would need to be adopted requiring a treatment plan and objective showing of improvement. This is a significant change from the current practice, which allows treatment to be compensable even if providing only palliative relief.

Recommendation #10– Level B

Consider requiring pre-approval for treatment after a maximum medical improvement status is reached as determined by the treating physician.

A treating physician can readily fix a likely maximum improvement point once a realistic treatment plan is formulated. Medical treatment is meant in the workers' compensation system to:

1. Stabilize and improve an employee's functioning to the point of returning as close as possible to the pre-injury state (not replicating that state).
2. Return the employee as close as possible to pre-injury work status.
3. Ensure as little disruption to the employee's employment status as possible.

Setting and reviewing a date for maximum medical improvement will serve as a milestone date to review the treatment plan and determine whether additional treatment is warranted to improve an injured workers' condition a return-to-work.

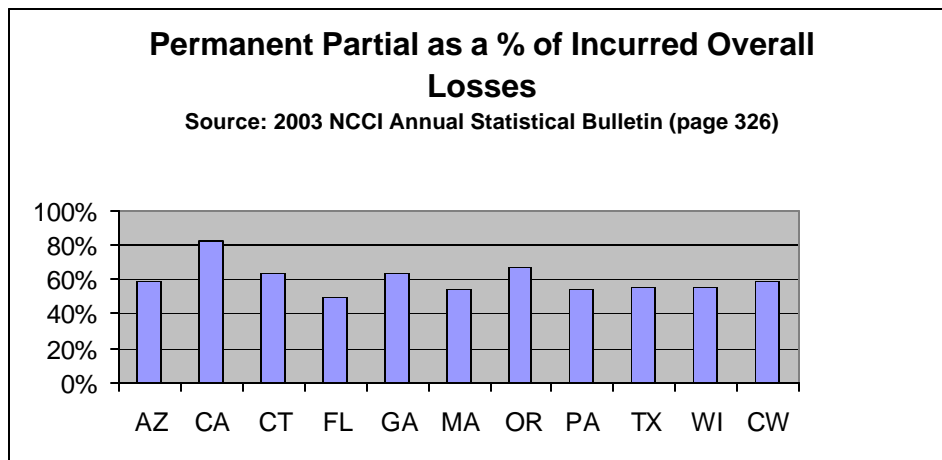
We believe pre-approval for treatment or a standard requiring cure and relief will provide an additional cost-control mechanism on treatment that cannot be justified. With California's higher-than-national utilization of physical medicine and chiropractic treatments, we believe further study of this recommendation may save medical costs on a long-term basis.

B. Permanent Disability

B. Permanent Disability

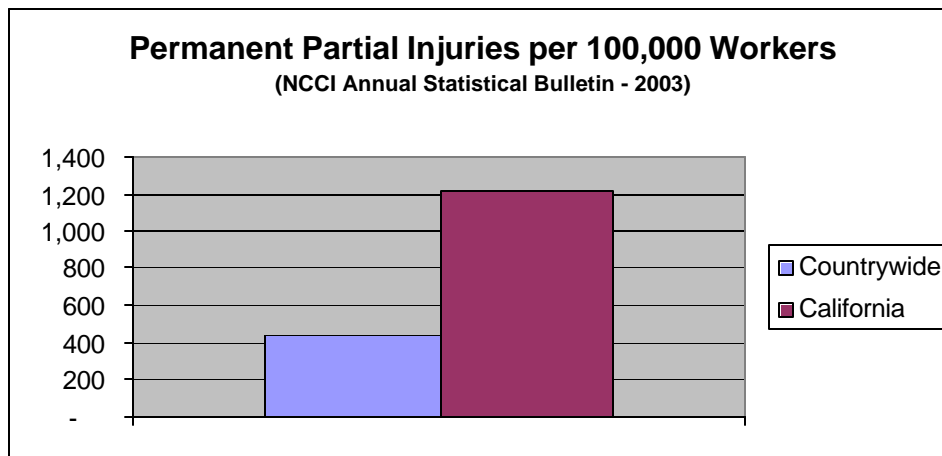
In reviewing the indemnity portion of the claims, the predominance of permanent partial claims in California is startling. The average state has 58.5% of its total costs in permanent partial cases. In California, total costs from the system attributable to permanent partial claims are 82.6%.⁵

Chart 30



This phenomenon is clear from the frequency of permanent partial claims per 100,000 workers. California has almost three times the number of permanent partials per 100,000 workers as the countrywide average.

Chart 31



⁵ NCCI Annual Statistical Bulletin 2003 page 326

This finding is very similar to the 81.5% of all costs attributed to permanent partial cases identified by WCIRB for policy year 1988 and cited in the 1992 WCRI Administrative Inventory. In other words, these statistics show 81% of the entire system costs are driven by less than 15% of the entire claims population.

With no significant changes to the application and mix of PD ratings, it should come as no surprise that system costs continue to be significantly driven by the application and mix of PD cases. Observations along this line were made by a number of the industry participants we talked to. We support the need for a redesign of the PD schedule to more closely match other states.

This average cost, driven by the unusually high number of permanent disabilities, has been and is being studied by various groups and organizations. The most prevalent remedy being suggested is to decrease the subjectivity of the system. The 1997 RAND Report *Findings and Recommendations on California's Permanent Partial Disability System* also found problems of rating consistency and predictability. As they stated, inconsistency undermines validity.

The application and understanding of California permanent disability schedule are somewhat subjective and vague according to many we spoke with. As a result, it is oftentimes difficult to come to an agreement on the permanent disability rating, which frequently leads to legal disputes. It is important that injured workers are fairly compensated for permanent injuries, and that payments are made in a timely manner. Because the current schedule is difficult to administer, it may lead to an unnecessary increase in litigation and delay in the delivery of benefits.

Recommendation #11– Level A

Consider adopting a more consistent and predictable permanency schedule that can be applied more consistently to targeted appropriate workers.

The implementation of a more objective rating schedule may bring some more predictability and consistency with the ratings. This change alone will go a long way to increasing the adequacy of case reserving and ultimate development of loss costs for the California system.

While there are many comments about the lack of predictability and the range of solutions for the current PD schedule, we believe a specific recommendation at this time is beyond the scope of this report and will be more than adequately addressed in the pending RAND study.

The pending RAND study on PD ratings should have some recommendations on the most objective method of assigning ratings for injured workers. As pointed out in the WCRI report, *Why are Benefit Delivery Expenses higher in California and Florida?* the multiple methods currently used for assessing PD ratings add complexity and, as we show, more

B. Permanent Disability

unpredictability to the system. We also believe the PD rating system adds uncertainty and delay in paying appropriate benefits in a more timely manner. We address this issue in the Administrative and Claims Regulatory Practices section.

Administrative and Claims Regulatory Practices



Solvency Oversight

Carrier Oversight and Liquidations

The large number of carrier liquidations in the past four years in California is a symptom of the inadequate pricing practices in California. Some carriers were irresponsible in their pricing practices in an attempt to gain market share and premium volume. The rest of the market, especially the domestic carriers, followed to preserve their market share and premiums. Many of these actions were exacerbated by the influx of cheap and plentiful reinsurance. For a more detailed discussion of this phenomenon, see the Ratemaking and Reinsurance sections of this report.

Unfortunately, many carriers could not recover from this pricing situation and were liquidated. When carriers restricted or stopped writing premium to attempt to return to a profitable position, no other carriers came forward to write additional premium, as they were also dealing with similar rate inadequacy issues. The majority of policies from liquidated carriers went to SCIF, which caused premium growth issues for SCIF.

Recommendation #12– Level B

CDI must change the emphasis in its regulation for solvency, moving from a passive monitoring and pre-approval of rate processes to an active analytical approach centering on liquidity.

It has been shown by studies by the American Insurance Association and the Illinois Insurance Department that the critical element in forecasting the continuing solvency of an insurance company is its ability to maintain sufficient liquidity.

Liquidity is the measure of cash and readily redeemable assets that are available to meet maturing liabilities. If an insurance company does not have sufficient liquidity, it is often forced into a position of selling fluctuating assets or not being able to meet its commitments outright.

AM Best addresses this question in its “Quantitative Analysis Report” which is used to financially rate companies. “Liquidity measures a company’s ability to meet its anticipated short-term and long-term obligations to policyholders and other creditors. A company’s liquidity depends upon the degree to which it can satisfy its financial obligations by holding cash and investments, which are sound, diversified and liquid. A high degree of liquidity enables an insurer to meet unexpected needs for cash without the untimely sale of investments or fixed assets which might result in substantial realized losses due to temporary market conditions and/or tax consequences.”

One area that CDI can immediately work to strengthen is utilizing a model of solvency testing that matched the liquidity of assets against the payout patterns of carriers. In

Administrative and Claims Regulatory Practices



determining whether there is a proper match, maturation dates of financial tools should reasonably match the payout pattern of reserves.

Rehabilitation actions can and should be taken with carriers exhibiting these warning signs. In order to resolve the issues and attempt to prevent insolvency, we believe CDI should be more aggressive in rehabilitating carriers.

If carriers are utilizing longer-term capital and liquidating before the maturation date to pay for current liabilities, there is a cash flow challenge with that company that needs to be monitored. CDI should work to ensure that carriers work to more closely match their payout pattern with retained securities.

Recommendation #13– Level B

Consider liquidating companies earlier in the rehabilitation process or severely restricting the time line for rehabilitation to maximize the security and deposits for use by the guarantors.

Earlier liquidation may be in the best financial interests of the guarantors and competitors.. It may be in the best interests of policymakers to cut their losses earlier while there are more securities available and thereby work to ensure that adequate reserves, payments and benefits are made going forward.

As detailed in a recent story in the LA Business Journal, the example of Fremont General shows that even with the cooperation and good faith negotiations from the CDI, Fremont was unable to right itself. Instead of receiving full surety on deposit, or demanding \$93 million to secure liabilities up front during rehabilitation, Fremont was allowed to operate for almost a year past the time CDI could have placed the company into conservatorship. After paying only \$20 million, the remaining liability of \$73 million now has been added to the already overburdened CIGA.

Reserving Practices and Ongoing Oversight

The workers' compensation insurance industry financial crisis is not limited to California. On a countrywide basis, the workers' compensation market has an estimated \$18 billion dollars in reserve deficiencies. According to WCIRB, the reserve deficiency at 12/31/02 in California was \$12.5 billion.

This reserve deficiency will need to be addressed before the system can regain financial stability. An improvement in the investment climate may help to finance needed reserve additions. Other strategies to reduce the reserve deficiencies include controlling system cost-drivers and adequate rates for exposures presented. This is a national problem that needs to be addressed by all states and carriers.

Administrative and Claims Regulatory Practices



Recommendation #14– Level B

CHSWC and CDI form a working group to identify and address the factors in California that are contributing to any reserve deficiencies in the California marketplace. Include members from WCIRB and NAIC, as well as members from the Garamendi Advisory groups.

According to comments and feedback from CDI and DWC staff, deteriorating claims practices of insolvent carriers were easy to spot during routine oversight and audit practices with carriers facing insolvency. We were unable to obtain access to a representative sample of the reserve histories for insolvent carriers.

This would be an excellent area for interagency cooperation and future studies to determine if there are practices that can be identified and used as early warning signs.

Recommendation #15– Level C

CDI look more closely at reserving and claims practices of the insolvent carriers to determine if there were changes in the reserving practices at some point prior to the insolvency that could have led to the faltering financial condition of the carriers.

We believe that part of the challenges leading to financial insolvency, especially in the regional and domestic market, is that the national carriers had a deeper management experience with workers' compensation issues when carriers faced deregulation in 1993 and 1994.

We believe the management of new carriers, especially domestics, should be reviewed closely and analyzed as part of the licensing and approval process for carriers when they do come back into the California market.

This will be especially important as new carriers come into the market and may attempt to retain managers with previous experience in carriers that were forced to insolvency. Management experience, knowledge and best practices play a key role in AM Best financial rating analysis and should be incorporated as part of the approval, licensing, oversight and regulatory actions taken by CDI.

Recommendation #16– Level C

CDI conduct a close review of the management structure, experience and background as part of its solvency oversight and approval for new carriers.

Administrative and Claims Regulatory Practices

Administrative and Claims Regulatory Practices



Funding Sources

The budget deficit facing California also impacts how quickly carriers will return to market in California. Many are concerned with an increase in user fees to support the Department of Industrial Relations - Division of Workers' Compensation (DWC) operating budget. They are unsure of the size and scope of the potential user fee and the impact that will have on cost structures, rates and profitability.

In most premium-based assessment mechanisms, carriers pay assessments based on premium volume or other market share measure. Carriers then build these assessments into an administrative or assessment load filed with their rates. With the assessments built into the rating structure, these costs are passed on to the insureds through higher premium rates.

With loss-based assessments, costs are generally incurred on a pay-as-you-go or arrears basis, so the load for these assessments is more difficult to determine prior to writing policies. Some jurisdictions allow the cost to be passed on as a surcharge.

We support the user fee changes recommended by Governor Davis. Almost all states fund their workers' compensation administration and regulatory functions from a user-based system. Relying on general funding sources, given the lack of predictability of legislative and budgetary challenges, is not the most effective method. Indeed, the 1972 National Commission on State Workmens' Compensation Laws recommended that the workers' compensation system be fully funded by participating carriers within each individual state system.

The method being considered by California ensures a consistent financing mechanism based upon the size of the market and the associated demand for regulation and oversight. As the National report noted, there should not be wide swings from year to year. The Commission further recommended "that the workmen's compensation agency be adequately funded by an assessment on insurance premiums or benefits paid plus an equivalent assessment against self-insurers."

We concur that this is a more equitable and reliable funding mechanism than depending on a general funding source.

System of Penalties

The cost of a carrier doing business in California is also more uncertain than other jurisdictions. One of those uncertainties is the system of fines and penalties on claim payors for claim handling issues. DWC has conducted audits on claim payer processes and regularly finds issues with claim handling processes that result in fines to the payor. On average, the DWC audit unit finds three citations and assesses on average nearly \$400

Administrative and Claims Regulatory Practices



per indemnity file audited. The total of penalties assessed in calendar year 2001 was almost \$1.8 million. This amount does not include self-assessed penalties.

There are penalties on claim payors for a number of issues, and some of these penalties, specifically the 5814 penalty payments, become liabilities for the life of the claim. These types of penalties can serve as an incentive to file ongoing medical bills and disputes, as there are added amounts to all future bills under 5814. These increased benefits do not go to the medical provider who suffered a delayed bill. Rather, they go to the injured worker.

Many of the familiar complaints we received regarding section 5814 penalties during the interview process for this report were originally cited and well summarized in the CHSWC 2000 *Issue Paper on Labor Code Section 5814*.

We believe there is disconnect between the penalty and the behavior. Increasing future amounts to claimants is not necessarily modifying claims paying behaviors.

Penalties to claim payors can come from DWC audits, administrative law judges, self-imposed penalties and DIR. The system of penalties is complex and confusing to the industry participants we spoke with. The impression given to claim payors is that there are many opportunities to be fined or penalized for their actions or inactions. There is little or no coordination of reviews and penalties in the system. In another section of our report, we recommend better communication and coordination between DWC and CDI in reviewing and monitoring the actions of claim payors.

We support the new profile audit process developed by and implemented by DWC audit division. We believe the process will improve the timeliness and validity of audits and allow the DWC to monitor more insurers and TPAs in the system.

The new profile audit process will also focus attention on the most egregious behavior and lessen the focus on less important notice-type penalties, which have been traditionally high-frequency violations with comparatively low severity.

Medical Penalties

Regardless of the date the medical bill was paid late, there is a 10% penalty for every bill going forward, which is payable directly to the claimant. We believe that this provides the claimant with an economic incentive to obtain unnecessary or excessive medical treatment, thereby artificially inflating the cost of the claim. Every time the claimant sees a medical provider, the bill is paid, and 10% of the billed fee is also paid to the employee as a penalty award.

If the goal of a regulatory penalty system is to equitably align penalty to behavior, the penalty award should go to the provider, as the provider is the one who suffered the original delay or unpaid bill, not the claimant.

Administrative and Claims Regulatory Practices



Recommendation #17– Level A

Adopt a tiered, one-time only penalty system on each medical bill paid late, rather than a running penalty based on what could have been only one late payment.

Recommendation #18– Level C

Medical penalties should be payable partially to the state and partially to the provider.

Medical penalties should be partially payable to the claimant/attorney and partially to the state. Including a portion for the state would serve to generate a source of revenue for the Department of Industrial Relations and reduce the need for some user fees. This recommendation would also help to decrease the adverse incentives for ongoing and frequent medical treatment.

Indemnity Penalties

The concept of an ongoing penalty is also currently utilized with regard to indemnity payments.

Recommendation #19– Level A

Adopt a tiered, one-time penalty structure should be adopted for indemnity late payments replacing the current ongoing/rolling 5814 fee.

Indemnity penalties should remain payable to the employee and his/her attorney, as the employee was at a disadvantage as a result of late payment or non-payment. We believe that the current penalty system invites excessive litigation, as attorneys may have economic incentive to file for excessive numbers of 5814 penalties.

General

Recommendation #20– Level A

Penalties should not be assessed on future benefits that are paid in an appropriate, timely manner.

The current method for penalizing medical benefits under Section 5814 appears to provide injured workers and their attorneys unjust economic gain, while not effectively serving as a significant punishment for carriers or deterrent to encourage timely and proper benefit payment. The system should be revised to provide for escalating and multiple penalties, depending on the offense.

Administrative and Claims Regulatory Practices



Recommendation #21– Level B

As an alternative to the 5814 structure, a stair stepping penalty structure similar to that used in many states should be adopted.

Example:

Late payment of indemnity benefits:

1st offense -- \$50

2nd offense -- \$100

3rd offense -- \$200

Up to a maximum of \$2,000 or some other significant sum per claim file.

SB 457 and AB 1480 both address some of the issues raised in this recommendation by placing increased monetary amounts to discourage egregious claims behavior, while capping the amount of additional benefits in the form of 5814 penalties at 25 % or \$500 of the delayed bill with a lifetime cap of \$5000 per injury claim.

Claims Practices

On February 4, 2003, Hays staff members met with representatives from the California DWC Audit Unit. The audit team consists of the director, one northern and one southern California supervisor, six northern California audit analysts, eight southern California audit analysts, and one clerk.

The audit team conducts approximately 100 audits per year in order to meet statutory requirements. The goal of the audit team is to measure carrier and TPA performance and determine whether penalty violations exist. If the audit team identifies a violation, it provides an explanation of the violation and how it came to its conclusion.

Administrative and Claims Regulatory Practices



Increase in Penalties

We had an opportunity to review several reports the Audit Unit completed for the California Legislature. Based on this data, we found that over the past few years, the number and value of penalties assessed have gradually increased. Based on observations of the audit staff, there may be several factors contributing to the increase in penalties including:

1. The Audit Unit now has more experience auditing workers' compensation files. It now understands the issues and it is therefore easier to identify what information is needed to evaluate the claim.
2. Based on conversations we had with DWC, discussions with several TPAs and carriers in the California marketplace, as well as audits we have conducted on California claims for our clients, it appears that several insurance carriers and administrators are hiring temporary adjusters, which may lead to inconsistent file handling practices.
3. It further appears, based on our interviews, that insurance carriers and third-party administrators have reduced or eliminated training programs. As a result, many adjusters may not receive adequate information regarding state regulations and internal file management processes. Some carriers or third-party administrators may view the penalties as a "cost of doing business", and in the long run, less costly than adding staff.

Timely Delivery of Benefits

In order to address the timely delivery of benefits in California, we also met with representatives of CIGA and reviewed a sample of penalty files they provided. Upon completion of our review with CIGA, certain file-handling patterns were noted.

It is apparent, based upon our discussions with regulators, carriers and other industry participants, that several carriers are having difficulty attracting and retaining experienced workers' compensation adjusters. Most of the files we reviewed had numerous adjusters assigned over the life of the claim,

Turnover of adjusters appears to be a concern within the industry. This observation was given by a number of insurance carrier representatives and was also identified as a challenge during interviews for the 1992 WCRI Administrative Inventory. Oftentimes, a transition of adjusters on a claim can lead to a lag in addressing important claim issues.

Adjusters may leave an organization for several reasons:

- Lack of training, which can lead to frustration and inability to understand job requirements.
- Higher salary.

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- High caseloads which set adjusters up for failure as they cannot adequately address all claim issues in a timely manner.

Offering training programs as recommended could provide new adjusters with the knowledge and confidence they need to stay in a claims management role. Encouraging longevity and increased qualifications of adjusters through certification and training is important to regulatory agencies, as it can increase the effectiveness of benefit delivery. While regulators cannot dictate salary levels, they can address longevity and qualifications in other ways.

Claims Training and Certification

Carriers have had to cut back on formal training programs, which intensifies mishandling concerns.

Recommendation #22– Level B

CDI should consider offering an initial training certification program for all California workers' compensation adjusters.

The program could incorporate a detailed analysis of current and prior labor codes, medical terminology, standard injury care and medical care allowed per labor codes, and litigation management concerns/strategies.

There are benefits to offering a standardized training program that all carriers, TPAs, and self-insured/self-administered employers could take advantage of. When adjusters are properly trained on standard workers' compensation rules and regulations, they are better prepared to make file-handling decisions, which should increase the timeliness and efficiency of benefit delivery.

Recommendation #23– Level B

CDI work to develop a training program specifically for newly hired claims adjusters. If the program is successful, CDI could consider different levels of certification for different positions (claims assistant, claims adjuster, senior adjuster, supervisor, manager, etc.).

If a program is offered at a reasonable cost, carriers and TPAs will be encouraged to send their teams through the training. Also, if a program is developed, the state is assured that a standardized training format is available to all stakeholders, which can lead to more consistent file-handling practices.

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The training could be conducted by an external training firm or by a division of CDI. CDI could require that adjusters complete the certification course before they are allowed to administer lost-time or complex claims. Although mandating claims licensure and certification is a tempting solution, the additional administrative burden and ongoing monitoring of any professional certification program outweighs the additional benefits of a more complete and ongoing certification and training process.

One current bill allows for a relatively simple certification/affirmation process by insurers to the CDI that carrier claims staff meet certain minimum standards outlined in rules to be created by CDI.

Another option is to consider adopting the requirements that self-insured employers require for their administrators.

Encouraging manageable caseloads is a critical issue for carriers and TPAs to address in order to retain qualified claims adjusters. If CDI or DWC focused additional efforts on tracking caseloads and published average caseloads identified during the audit process, that would go a long way toward eliminating some of the poor claims practices which not only delay benefits, but also lead to inadequate reserving practices.

Recommendation #24– Level C

DWC Audit unit monitor and publish average lost-time and medical-only caseloads by audit location. This can be incorporated into the profile audit process designed by CHSWC and implemented by DWC.

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Claims Caseloads

Focusing on manageable caseloads and publishing these averages in the annual audit report may go a longer way toward eliminating some of the poor claims practices which not only delay benefits, but also lead to inadequate reserving practices which undermine the entire ratemaking and loss development process for the industry.

Having the DWC Audit Unit analyze and publish audited average caseloads, reserving practices and communication strategies for TPAs and carriers will also go a long way to improving claims behavior and will increase timeliness and accuracy of benefit and bill payments made for injured workers.

One way insurers may consider increasing claim staff levels and reduce caseloads in the process is to reduce and internalize current expenditures for external bill review and medical cost-control services.

Using some average numbers from the 1999 WCRI report *Benchmarking the Performance of California*, attempting to reduce medical cost-control utilization by half could support additional internal technical bill review staff, as well as provide additional savings to hire additional claims staff. These actions could help to reduce average caseloads and improve claims payment accuracy and timeliness.

We made the assumption that utilization rates would plateau at the 75% level of indemnity cases as observed in that analysis. We also assumed the average cost of case per year would grow at a 20% rate, more moderately than the historical rate.

This analysis indicates that a reduction of bill review utilization based on savings from indemnity-only claims could provide significant savings if they were internalized and cut in half. Internalizing costs could be accomplished through electronic bill submission, review and claims software packages that are readily available to the industry. These additional dollars could then be utilized to increase internal staffing levels and reduce caseloads.

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Table 3

Accident Year	1994	1995	1996	1997	1998	1999	2000	2001	2002
Indemnity Case Load	200	200	200	200	200	200	200	200	200
% Indemnity Cases Using Med Contain	67%	74%	80%	75%	75%	75%	75%	75%	75%
Average Containment Cost Per Case	\$286	\$374	\$501	\$601	\$721	\$866	\$1,039	\$1,247	\$1,496
Total Costs / Claims Adjuster	\$38,324	\$55,352	\$80,160	\$90,180	\$108,216	\$129,859	\$155,831	\$186,997	\$224,397
Cost Savings to Apply to New Staff	\$19,162	\$27,676	\$40,080	\$45,090	\$54,108	\$64,930	\$77,916	\$93,499	\$112,198

This model shows that given the assumptions stated, there may be some benefit to developing and internalizing medical cost-containment and bill-review functions. An electronic bill submission, review and payment system may increase efficiencies and reduce overhead, thereby adjusting expenses and allow for more quality claims handling.

In addition, with the publication of average caseloads, these measures can be an important way to increase efficiencies in the system and improve delivery and timeliness of payments and bills.

Claims Reserving

We understand that a proposal is being considered to bring workers' compensation bad-faith claims practices under the jurisdiction of the Commissioner of Insurance. While this is a unique idea that may focus more attention on poor claims administration, we believe it duplicates the current regulatory oversight authority already resting with DIR and DWC. We do not recommend additional regulatory oversight in this area beyond the new initiatives DWC is implementing with more thorough profile audits.

While we can recommend some best practices, such as timely establishment of realistic reserves, regular review of claims by supervisors and mandatory reserve updating, we are hesitant to recommend that reserving standards be adopted across the industry in California. Individual carriers and self-insured employers with their TPAs are in a better

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position to create and implement individually constructed reserve policies as long as they provide a reasonable analysis of future liabilities.

Electronic reserving systems, which use intelligent reserve analysis and diagnosis codes can be useful in establishing consistency and reserve adequacy in claims administration operations.

Recommendation #25– Level C

As a best practice, require that carriers adopt an electronic reserving program to assist in timely, accurately and adequately setting reserves consistent with state-specific system experience.

With the ongoing threat of direct action bad faith litigation from insureds, we believe that establishing standards for all carriers invites additional litigation opportunities if and when standards could not be strictly followed.

The appeal of premium reimbursements to plaintiffs through direct action suits against reserving practices is strong in the short-term, but we believe the practice will prove disastrous in the long-run if carriers are discouraged from establishing realistic reserves by the threat of legal action.

Recommendation #26– Level B

Study the direct action lawsuits to better understand the impact they have on ratemaking and reserving adequacy for the industry. Determine if removing the direct action lawsuits is justified in the workers' compensation system.

Claim reserves are critical to supporting sound cost-development trends for advisory rates. This will have the long-term impact of increasing pricing pressures years later as rates become more and more insufficient. We are seeing this phenomenon right now. Allowing and encouraging lawsuits to go on will only exacerbate the problem in the future.

Over the period under study, the quality of claims handling declined substantially. Both the number of violations and the penalties assigned increased substantially. This was true despite a declining total number of cases in the California workers' compensation system.

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Claims Delivery Practices

The deterioration in claims handling, however, was not necessarily reflected in the level of unpaid compensation. Despite increases in the average indemnity paid per case, the average amount of unpaid compensation in indemnity files does not have a clear trend.

Looking at differences between solvent and insolvent entities, there is no indication that claims administration by entities that became insolvent during this period had worse claims handling practices prior to being taken over by CIGA or SIP.

While on average, insolvent entities had more frequent violations and more penalties assessed, this difference can be explained by the greater portion of insolvent locations that were targeted for audits. The results of random audits were virtually indistinguishable between solvent and insolvent locations.

This does leave open the question of why the locations that eventually became insolvent were more likely to be singled out for targeted audits. The number of targeted audits at locations that eventually were insolvent is small, and it is difficult to reach conclusions.

There is no absolute measure of “good” claims handling, and consequently, no way to judge whether current claims practices are “adequate.” However, the continued decline in claims practices suggests that the California system is going in the wrong direction, depriving workers of timely compensation and information and potentially burdening employers with higher costs through increased litigation and additional labor-management problems.

We cannot say definitively that this decline in quality is a result of open rating and the price competition that followed. The evidence about the timing of the changes in practice and the limited changes seen on self-insured/self-administered employers suggests a relationship. It is not clear that some form of re-regulation of the insurance market will lead to better claims practices. It might be appropriate to consider standards for claims handling.

One important step has already been made to improve claims handling. AB-749 adopted nearly all of the recommendations made by CHSWC for improving the audit process. These changes eliminate much of the burden of the audit on locations with good practices and increase substantially the penalties on the worse performing locations. This will increase substantially the incentives for improving claims handling and the visibility of both the best and worst performers.

One question we were asked to look at more closely was:

Would behaviors of poorly financed and poorly performing carriers correlate with the number and amounts of penalties assessed against those carriers?

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The thought is that poor loss development, reserving and claims administration were signs of manipulation or were some financial weakness indicator. We believed the carriers that went insolvent would exhibit higher penalty rates for claims prior to insolvency.

The reasons behind that premise were that as financial issues became more tenuous, there would be an agency effect to take riskier actions which, on the claims side, would lead to less accurate claims payment, thereby opening themselves up to more penalties from regulators.

The work for this section of the report was done by Frank Neuhauser at UC Berkley. For the complete study paper, see Appendix One.

Comparing Solvent and Insolvent Insurers/Self-insured Employers

An interesting question, beyond changes in the quality of claims handling over time, is whether or not insolvent insurers handled their claims less well than insurers and self-insured employers that remained solvent. This could be either a cause of insolvency, an effect of insolvency, or both. Bad business practice may reflect itself in poor claims handling, leading to more disputes, more penalties, higher costs, and ultimately, a higher chance of insolvency. On the other hand, weak financials may lead to cuts in claims handling staff and budget or switching to lower-budget TPAs.

The result of poor claims handling is felt by employers and injured workers. Employers face the potentially higher cost of poor administration. Employees risk loss of benefits and longer delays until disputes are resolved and benefits paid. If insolvencies have an important effect on claims handling, then statutory and regulatory action to reduce the risk of insolvencies becomes even more of a concern.

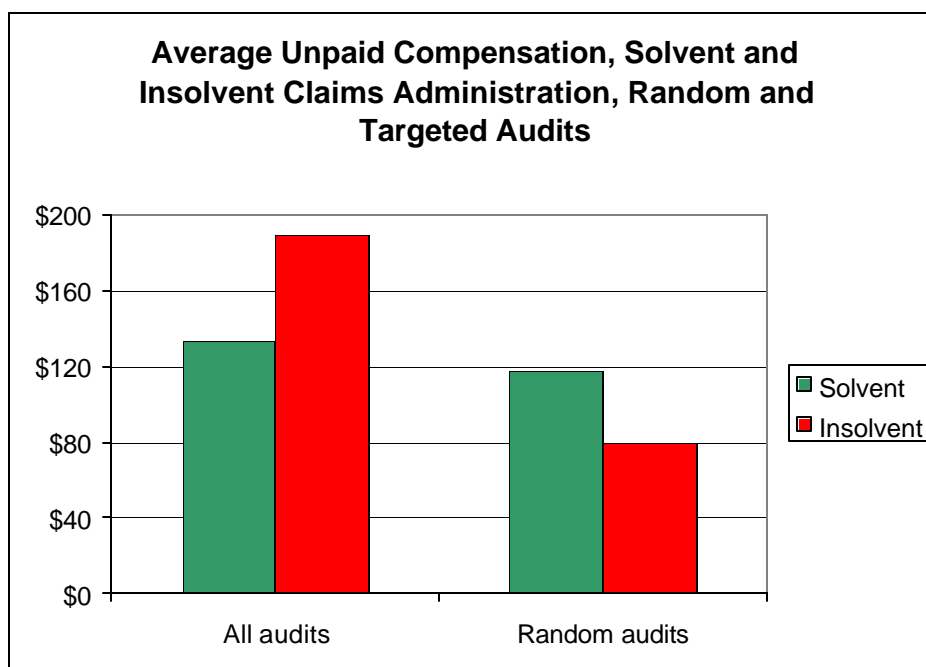
We identified audit locations as “insolvent” based on whether the insurer or self-insured/self-administered employer ultimately went insolvent or bankrupt. If it was a TPA with a sole client that went insolvent or bankrupt, that location was also identified as “insolvent.” Of the 376 audits for which we had data between 1994 and 2001, 345 (91.8%) were classified as solvent, 28 (7.5%) as insolvent (by 2002), and 4 had inconclusive data.

The following chart compares the two groups of carriers on the important dimension of unpaid compensation. The comparison is on the average amount of unpaid compensation on indemnity files audited. When all audits are included (random and targeted), insolvent carriers averaged \$56 (42%) more unpaid compensation per indemnity case than those that remained solvent.

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Chart 32



However, audits of insolvent locations (26.7%) were twice as likely to be targeted audits as audits of solvent locations (13.3%). When we use just the random audits, the insolvent locations performed slightly better (but not statistically significant.) The performance of insolvent locations, on the dimension of paying compensation, appears at least as good as that of those administrators that remained solvent though this entire period. That still leaves open the question of why the insolvent locations were more likely to be targeted. We cannot answer that question with the data we had available.

We also evaluated the quality of claims handling for these two groups using the measures of the average number of violations found per indemnity file and the average amount of penalty dollars assessed per indemnity file. On both of these measures, the insolvent locations performed more poorly when all audits (targeted and random) were used, but the two groups were identical when only the random audits were used.

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Chart 33

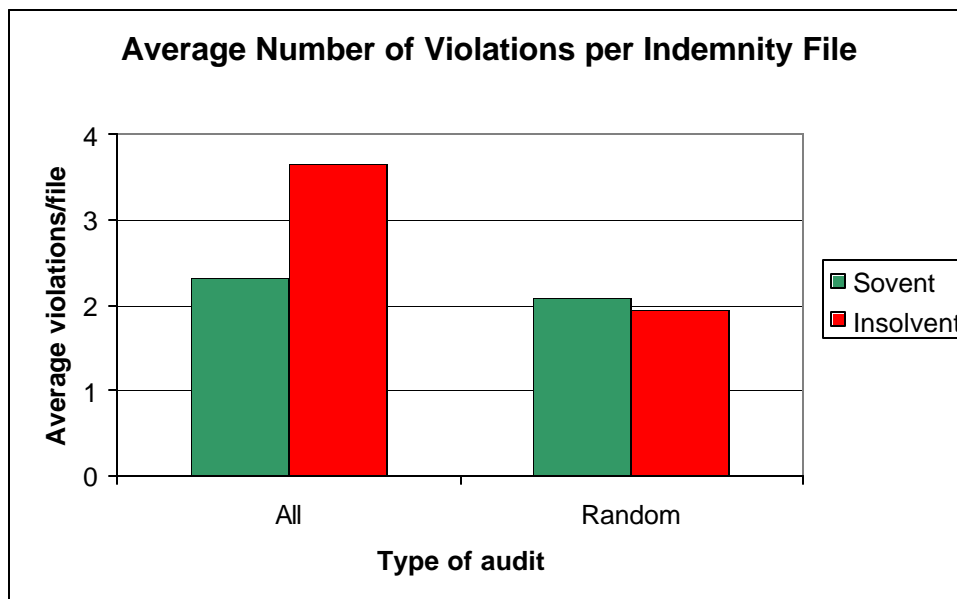
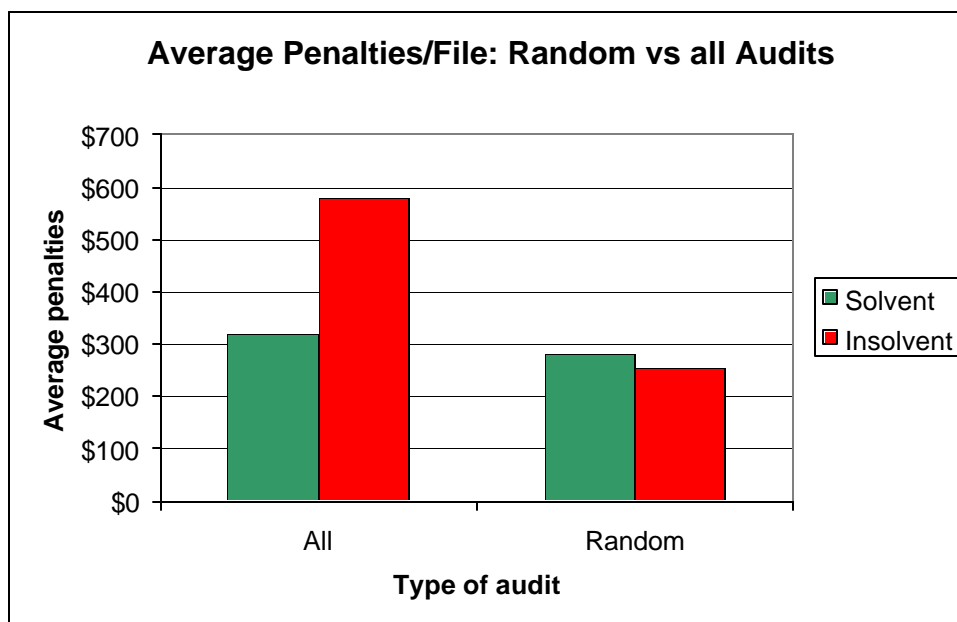


Chart 34



Administrative and Claims Regulatory Practices



We recommend no changes to the regulatory claims review and oversight by DWC on carriers that are in rehabilitation. We see no evidence that the financial weakness of the insurer or self-insured employer causes poorer claims handling that would have had a negative impact on workers or employers.

The reader should keep in mind that this might underestimate the differences between solvent and insolvent entities. As we saw in the previous section, violations, penalties and, possibly, average unpaid compensation have been increasing over time, but insolvent entities will be less and less likely to be audited over time as they exit the market. This could lead to a downward bias in estimates of violations for insolvent entities.

Also, there is evidence that once an entity becomes insolvent or a self-insured employer enters bankruptcy, there can be substantial delays in the next series of payments to workers while a transition is arranged by the CIGA or SIP. We were unable to measure this effect during this study.

Additionally, we looked at a self-selected sample of 62 claims administered by CIGA. We looked at claims handling and reserving practices from insolvent carriers prior to the time when CIGA took over administration. Our beliefs were that we would find inadequate reserving practices, which led to the disastrous financial conditions and insufficient security after carriers were liquidated.

These observations were made by many in the industry and observations from CIGA and its agents after taking over cases and attempting to accurately report liabilities. Part of the challenge for CIGA is to explain why liabilities are so much more than what was anticipated after receiving claims.

Our review and observations of the limited number of files and interviews support the contention that reserving practices, if not claims payment practices, were inadequately documented and not focused on to the extent they needed to responsibly manage claims and reserves on a company-wide basis for cases we saw.

We observed missing, incomplete and inadequately completed reserve worksheets. We believe this lack of documentation contributes to the difficulty for CIGA and its TPAs to adequately capture and quantify the amounts of liabilities owed on future claims. This lack of information forces them to spend an inordinate amount of time developing reserves and may take resources from the actual delivery of benefits.

In order to more accurately document liabilities on a system-wide basis:

Recommendation #27– Level B

DWC adopt a reserve review component to its claims audit process and make referrals to CDI financial auditing sections when warning signs are detected.

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This review by DWC does not need to analyze the accuracy or adequacy of reserves, only whether they exist and have been updated on a regular basis.

This two-way communication between CDI and DWC can improve the regulatory oversight of carriers within the current structure without needing to increase regulatory schema.

Other Administrative Recommendations

Recommendation #28– Level B

The practices and procedures identified by DWC in the annual profile audit of the highest scoring carriers and TPAs be highlighted as “best practices” for utilization by the remaining industry participants.

In addition to serving as a powerful marketing tool, the publication of these scores will shed light on the performance of carriers. Those with higher scores should be touted as having practices that reduce the likelihood of penalties.

Recommendation #29– Level A

Implement uniform billing formats and electronic payment systems to more closely replicate with other payor billing system arrangements.

Electronic billing and explanation of benefits (EOB) are much more familiar to the majority of medical providers than current variations in billing. The benefit of uniform billing is that bills are submitted in identical format and allow bill review and auditing to occur much more expeditiously and economically in-house or externally with a standard format for carriers and providers to use.

With HIPAA regulations in place, which establish standards for electronic claims submission, this recommendation should help streamline the data privacy requirements and reporting criteria required of providers.

UB 92 and HCFA 1500 formatted billing statements are very familiar to providers throughout the country and in California. This recommendation makes even more sense when reviewing the statistics that 90% of California providers treat fewer than two injured workers in the workers’ compensation system annually. If billing formulas and formats were adopted to make it more consistent for the providers, we believe implementing a more uniform billing system would help to reduce disputes, rejected bills and delays in payments to providers.

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Administrative Court System

Predictability in the court system needs to be improved. With the diversity of costs and awards across geographic areas in the state, it is very difficult to produce and write rates that are adequate equally across the state. There are real differences shown by previous WCRI studies and the perceived differences offered as examples by many of those we interviewed across and between the local California workers' compensation courts. These divergent outcomes in similar cases could be explained by differences in claims administration, PD and other court findings.

We believe that making the court system more predictable across the state will improve predictability of cases and outcomes. This will help to improve the cost and case reserve projections of self-insured employers and insurers.

We applaud the efforts of the DWC in creating and filling a Presiding Administrative Law Judge position. In addition to regular meetings, a renewed focus on training and a focus on improved administrative consistency are already being implemented by the Presiding Judge. We believe the following initiatives which we endorse will have a positive impact on the consistency and speed of the system:

Recommendation #30 Level A

Fully fund and fill the administrative support staff as recommended in the RAND study *Improving Dispute Resolution for California's Injured Workers*

The Presiding Judge should:

Recommendation #31– Level B

Increase focus on training and communication of administrative law judges.

Here again, improving the consistency of the system in handling disputes is of utmost importance in predicting outcomes and increasing system predictability. Comments we received indicated that the focus on training has suffered and decreased over time as delays in the court system have increased.

As indicated in the RAND/ CHSWC Judicial Study summary from September 2001, improving consistency is a key component of an effective court system. Consistency improves the ability of a system to operate and for participants to predict and adequately reserve and ultimately price the anticipated outcomes.

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Recommendation #32– Level A

Implement an anonymous and random judicial survey or feedback process for participants in the administrative law dispute resolution system.

Feedback and observations from participants are key to servicing those who utilize the system. Results from those surveys can help to focus training resources and efforts to areas that are identified as not as strong as others.

As in the medical field, peer feedback, comparison and ratings systems have been shown to be a very effective way to change behaviors.

Recommendation #33– Level C

Develop and adopt a judicial code of conduct in conjunction with the recommended judicial survey program.

This code may also encourage and improve adherence to accepted practices and procedures of the administrative court system in California and make the process more consistent and predictable for all participants.

States that have adopted judicial performance reviews (Arizona, Minnesota, Oklahoma) have seen an improvement in performance and are able to document increases in satisfaction and credibility from those who use the system on a regular basis. Evaluation tools can be adopted from district courts, other administrative court systems and judicial associations. The chief and presiding judges could utilize existing resources from the State of California Commission on Judicial Performance.

Additionally, we believe the Presiding Judge should work with the various area judges to:

Recommendation #34– Level A

Implement and enforce a stricter and more consistent interpretation of filing requirements, timelines, and supporting documentation on both parties.

Practitioners on both sides of the bar understand and believe that timeliness and consistency in receiving decisions and consistent interpretation of rules of practice vary widely from one judge to another and from one court to another. Training and monitoring performance standards for timeliness of cases will help to compare and contrast the outcomes of various jurisdictions.

Administrative and Claims Regulatory Practices



Concerns and comments about differences in the courts have not quieted since the 1992 WCRI Administrative Inventory was completed. That report noted a number of concerns about the court system and its need for consistency in practices.

There is general agreement from participants that uniformity and consistency in an administrative court system are necessary for improving credibility and timeliness and good faith cooperation from both parties when the rules are fairly and consistently applied.

Recommendation #35– Level B

Adopt a presumption of fairness for compromise and releases when all parties are represented by licensed attorneys.

There is not a great deal of sense in requiring a review for compromise and release settlement agreements that have been reviewed and explained to clients who are represented by licensed attorneys. With enforcement of existing rules of practice and ethics rules, the likelihood for abuse is minimal.

This will help to eliminate inconsistency that participants observe in the factors and processes judges use to review and approve compromise and release agreements. Although compromise and release agreements may by nature restrict access to future benefits, it is reasonable to assume that the advocacy and counselor role provided by the applicant attorney will protect and educate the employees.

Corporate counsel can provide that same protection and education role for the payors and participating third-party participants.

Market Challenges for SCIF

Carriers and market participants we interviewed are concerned about the viability of the State Compensation Insurance Fund (SCIF) and how they may bear the responsibility for supporting SCIF if their financial condition worsens. SCIF serves as the residual market-of-last-resort, and carriers are generally required to financially support any market shortfalls in residual markets through assessments based on market share.

Additionally, if SCIF were to become insolvent and liquidated, there is little ability for the overburdened CIGA and its funding mechanism to adequately handle an insolvency of this size.

Carriers are reluctant to increase their market share until they understand how SCIF is going to be financially stabilized. Assuming that any ongoing shortfalls from the residual market accounts will continue to be made up by underwriting profits from competitive policyholders at SCIF is shortsighted and inequitable.

SCIF has an unacceptable surplus-to-premium ratio, which is one factor serving to bring it under regulatory oversight by the California CDI. SCIF fell below company action level of RBC regulation in early 2002. While not officially under RBC statutory oversight regulations, because it is a monoline carrier, SCIF voluntarily complied with those requirements at the time.

The adequacy of a company's capital is assessed by comparing its total adjusted capital, which is basically its net worth, with its RBC, an amount of capital that reflects the level of risk the company has assumed. The greater the total riskiness, the greater the minimum financial cushion must be.

The result is expressed as the company's RBC ratio. Ratios are categorized in six levels or zones that run from adequate (125 percent and higher) to mandatory control or below 35 percent, at which point the insurance commissioner is authorized to seize the company unless there is some reasonable expectation that the circumstances that caused the depletion of capital will be remedied within 90 days.

According to the RBC and other financial requirements monitored by CDI, SCIF is essentially insolvent. Its surplus position has plateaued at about \$1.4 billion with premium writing of \$5.5 billion. Premium-to-surplus ratio is about 4 to 1. Usually, conservative mutual insurance carriers and other state funds attempt to maintain a 1 to 1 ratio or at most, a 2 to 1 ratio as acceptable.

Recent opinions from CDI and SCIF's public accounting firm PriceWaterhouseCoopers indicate that surplus may be as low as \$450 million. If this were the case, the surplus ratio is now 11 to 1.

SCIF has seen an extraordinary growth in premium volume. Premium volume more than doubled in one year alone from \$1.7 in 2000 to \$3.6 billion in 2001. There was no corresponding increase in surplus to maintain healthy ratios. This unbalanced ratio is a significant indicator cited by AM Best and others as a sign of challenges to the ongoing financial strength and solvency of carriers.

SCIF has seen its AM Best ratings slip from A- (excellent) at the end of 1998 to B++ in mid-2000 to B+ (both very good) in March 2001, to a vulnerable rating B- (fair).

Thereafter, SCIF disagreed with the Best ratings and asked that the ratings be suspended. Best has not updated ratings for SCIF since April 2002.

Commenting on the B- rating in April of 2002, Best cited concerns with the substantial growth and concentration of market share, sizeable reserve deficiency, four years of operating losses and an increasing development pressure on future reserve developments. Most of the deterioration was caused by the competitive nature and overall challenges to the California marketplace.

AM Best ratings are a widely accepted measure of financial strength for insurance companies. Best strives to perform analysis that will serve proactively to encourage good management practices and improve the industry's solvency and financial strength for policyholder benefit.

Best performs an analysis of key financials, operating ratios and profile in order to arrive at a rating. The rating process looks at a wide range of information including financial ratios, reserve practices, reinsurance arrangements, book of business, diversification, insurance market risk and management practices.

SCIF has some valid concerns that its book of business includes the entire residual market, which certainly drags down its profitability and financial strength. The Best process, although not uniformly accepted, provides a comparable measuring tool for property and casualty carriers.

Market Mix

At the end of calendar year 2002, SCIF had a market share of 50.5% of written premium in California due to the liquidation of other workers' compensation carriers and their inability to reject any application for coverage being the residual market of last resort.

The advantage to having a state fund such as SCIF is that it guarantees access to reasonably priced coverage. The state generally acts as surety for state funds in practice, if not statutory reality.

Many observers we spoke with indicate SCIF and other state fund reserving practices are more conservative and, with the experience in California, it can be argued, also more accurate than other carrier practices in the industry.

According to a recent Conning Research study, the average market share for the 21 competitive state funds is 33% of written premium. This huge discrepancy in SCIF market share indicates that there is little activity from carriers in writing new premium in California. No other carrier in the market held more than 5% of written premium.

Other than a relatively small \$50 million capacity from Employers Direct Insurance Company, no other new carriers have entered the market. This additional capacity was more than offset by the 2003 departure of Cal Indemnity and its \$80 million capacity. Carriers with a market presence in California may have increased their capacity, but we did not analyze the market structure to that level of detail.

SCIF rates are rising dramatically with a 23% increase filed in 2003 following a 22% filed increase in 2002. These help to make up for previous rate inadequacy and to support the huge increase in premium volume coming to SCIF. These increases will put additional pressure on employers to find alternative solutions for their workers' compensation coverage.

One of the main questions we are attempting to answer with this study is when new capacity from existing and new carriers will come back to the market creating additional competition and access for reasonably priced coverage for employers.

As we stated in the Executive Summary, based on interviews and article reviews from carrier and trade association representatives, predictability and stability in the system are the keys to getting carriers willing to risk their capital in the California workers' compensation market.

One of the largest challenges is to shift the system burden from SCIF back to other areas of the market. In California, SCIF serves two wholly separate roles in providing insurance coverage:

1. SCIF is to provide a permanent market for workers' compensation at a cost with no financial obligation to the public.
2. SCIF is to provide insurance as a residual market. The practice of accepting all risks, even unprofitable ones, must necessarily be subsidized by other policyholders and the public.

As such, that segment of California, like other assigned risk plans across the country, is invariably seeing an increase in premium volume, payroll and policies. The difficulty in California is that there is no distinction between the competitive policies and those unable to obtain competitive coverage in the open market.

These two roles, while important to the stabilization of the market, cannot co-exist adequately without transparency of the unprofitable policies. SCIF, its regulator, and the public, need to be able to distinguish and track these separate and distinct types of risks by underwriting profitability.

If SCIF were not subsidizing the residual market losses from competitive policyholders, the rates and costs to those assigned risk policies would indeed increase. The positive is that the remaining competitive risk policyholders would likely see a decrease in their premiums.

Recommendation #36– Level A

Distinguish and track the results from the residual market or “Assigned Risk” policies from those that are competitively written by SCIF.

Our analysis indicates the loss ratios of policies under \$1000, many of those that are at SCIF for market of last resort, far exceed those at larger premium volumes. This indicates regular policies are subsidizing unprofitable policies. Loss experience and pricing for these two distinct classes need to be adequately tracked to make SCIF profitable on an underwriting basis for all policyholders.

Subsidization of residual markets will not be as high when the market is shrinking. As residuals grow, the burden increases. In California and other states, during normal market conditions when 3 to 8% of the market is residual, the burden is on a smaller market segment, the other policyholders who happen to be written at SCIF.

We believe a better and more equitable solution is to spread those underwriting losses across a pool of 100% of the insured market. This solution would be in addition to appropriately increasing the pricing for assigned risk policies.

The recommendation to study and create a separate account for assigned risk policies was also made as part of the 1992 Rate Oversight Commission report. Over time, the inability of SCIF to appropriately segregate and price these risks is providing significant challenge to its ability to adequately underwrite, price and appropriately address the unique characteristics of these assigned risks.

Underwriting review can appropriately select and segregate policies in the residual assigned risk market by size, loss experience, new businesses and management attitude towards safety or businesses performing work in high-hazard class codes. The program can be designed to allow companies to get out of the assigned risk account by showing a safe loss history for a reasonable period of time such as three years.

There are three generally practiced methods to establishing and tracking loss development of residual markets or assigned risk plans across the country. We recommend adoption of any of the following options:

Recommendation #37– Level A

Create a separate and distinguishable account within SCIF for the purposes of monitoring, underwriting and pricing those risks written as a residual market.

Recommendation #38– Level B

Create a separate Assigned Risk Pool (ARP) outside SCIF administered on a contract basis. This can be managed by a separate company, or can be conjoined with other state assigned risk pools in the National Workers' Compensation Reinsurance Pool.

California already has a similar model for the auto insurance market in the California Automobile Assigned Risk Plan. This works as a mechanism to ensure all drivers have access to basic automobile coverage.

Recommendation #39– Level B

Create a FAIR (Fair Access to Insurance Requirements) plan. Many states utilize this to ensure access to property insurance for business and homeowners or auto policies.

FAIR plans provide limited insurance when coverage is not available from the private market. The California FAIR Plan Association for property risks and the California Earthquake Authority are versions of FAIR plans. Typically, FAIR and ARP plans require all participating carriers in the market to provide coverage allocated by market share. Coverage is provided at a cost plus basis for processing policies and requires carriers to retain the risk.

As with the ARP model, policies are by no means the most affordable, but they do offer a guaranteed coverage for employers.

Underwriting losses and shortfalls for all three models could be made up with a separate assessment spread across the remaining, but larger pool of the insured market. Although these costs will still be borne by the public, the industry widely accepts this surcharge mechanism across the country as a way to adequately fund losses for ARPs. Transparency of these costs to the system now is preferable to the continued uncertainty of unfunded liabilities residing in market-of-last-resort policies.

We believe the alternative to no segregation is to place additional stress on SCIF and its remaining book of competitive business. This stress will add to the pressures forcing the company to continue operating in non-compliance with RBC requirements. If at some point SCIF becomes insolvent through continued unprofitable underwriting, the state

would likely look to policyholders and remaining carriers as a source of funding the insolvency.

Again, we believe this is a more transparent and equitable solution for funding any shortfalls from this segment of the market. The known and visible liabilities are usually preferable to the larger unknown liabilities of the entire SCIF book becoming unsustainable.

If funding shortfalls for residual market policies are not adequately addressed, it has the possibility of pulling SCIF and, ultimately, the entire system down. Those risks at least need to be made transparent to the system and market players. Currently, there is no way to tier rate or distinguish those policies.

California is poised to repeat the dangerous and painful lessons from the 1980's when carriers could not or would not support the residual markets (SCIF in California) and left entire state markets underserved by competitive carriers. Up to 85% of the employers were forced to the residual markets (SCIF) in Louisiana, Maine, Rhode Island and Texas. This very real possibility is presenting itself with the combination of SCIF financial oversight status and the CIGA funding crisis.

Marketplace Dislocations and the State Fund

Market conditions have been severely disrupted by the company pricing irregularities, so much so that the domestic workers' compensation market has been thrown into turmoil. In 1997, of the top ten companies (excluding SCIF), three companies were domestic workers' compensation insurers writing 17% of the workers' compensation market at that point. These three represented three of the top five and the top two carriers in the market.

At that same time, the State Fund was also writing approximately 17% of the business. Of the top ten insurance companies, seven were foreign (out-of-state based insurers.) These companies wrote 26% of the market in 1997. The top ten carriers and SCIF were writing 60% of the business.

By the end of 2001, the same companies that occupied the top ten in 1997 had developed in the following ways: domestic companies were no longer present; out-of-state companies had maintained the same share of the market; and the State Fund had absorbed the domestic market share as well as most of the market share of those out-of-state carriers that had gone insolvent.

The existence of the State Fund had proven to be a saving element in this process, absorbing the business from the insolvent carriers. However, the process was not without its flaws. Unfortunately, for a period immediately after the initiation of open rating, the State Fund became a competitor in the market, a market that we have shown to be irrational. By competing in that irrational market, the State Fund had potentially eroded

its financial strength and raised the possibility of not being able to perform its market-of-last-resort function.

It is our recommendation that in order to reduce the current over-dependence on SCIF and encourage the expansion of diversified national carriers that would provide a solvent market place,⁶ the following changes should be made:

Recommendation #40– Level A

Regulate the State Fund under a minimum rate law type provision with mandated minimum premium rates based on loss-cost factors in the range of 1.33 to 1.5 times WCIRB's loss cost.

Requiring SCIF to write rates based on the minimum rate method will help to ensure financial stability and will also provide a continued and ready market for insureds, as well as help to ensure financial stability for SCIF and provide a continued ready and accessible market for California employers.

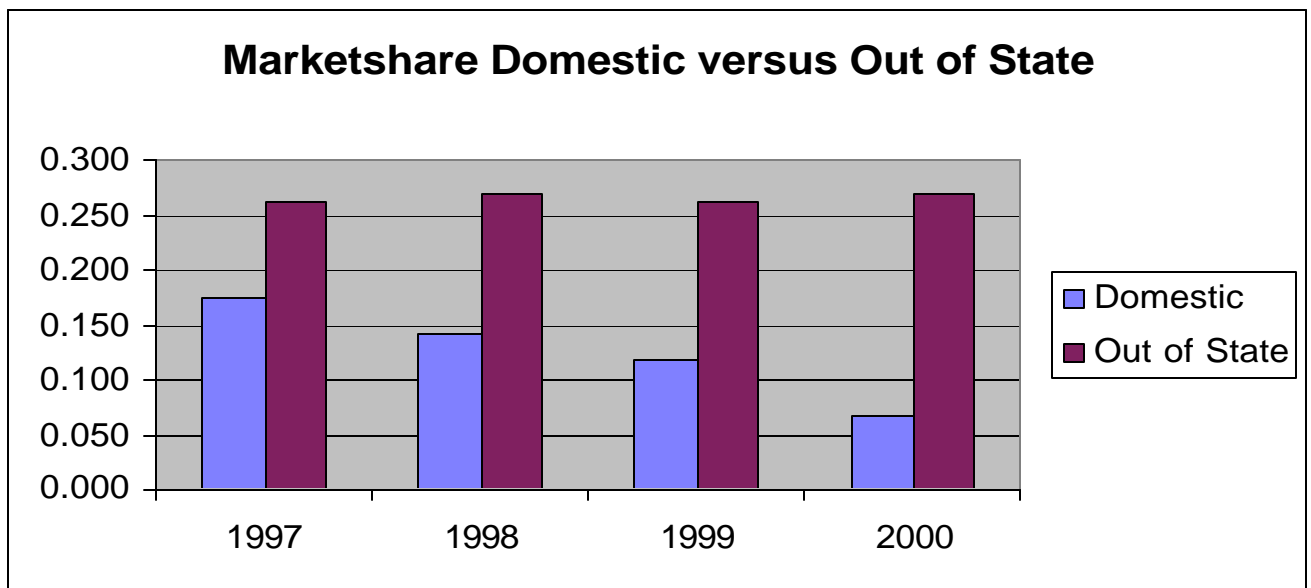
Recommendation #41– Level A

Require that the State Fund pay up to 60% of its annual earned surplus to its policyholders in the form of dividends.

CDI is asking to have more input on the management structure of SCIF. We believe CDI should have some more review of all carriers that request new licensure to write workers' compensation. With the crisis and unique challenges in the workers' compensation insurance market, background and experience on a national level are important. We therefore believe that carriers should have some national management experience especially in California's unregulated rate environment.

⁶ The financial analysts believe that for a company to be financially viable in the insurance business, it should have a diversification, either geographical or by product. The insolvency of many California domestic workers' compensation specialty writers gives credence to that theory. As a result, we believe a top priority is to foster companies with multiple state writings or a broad-based product mix.

Chart 35



Although SCIF now writes more than 50% of the market by written premium, we are concerned about the rate of depopulation and some of the steps recommended by the CDI for depopulating SCIF.

Depopulation needs to occur at a reasonable rate so that cash flow is sufficient to pay for already incurred and payable losses from past policies. Without a reasonable plan, SCIF will face a catastrophic cash crunch situation that has not been seen in the market and which will likely put even more strain on its financial health and improvement.

If premium volume shrinks too quickly, the monies from ongoing premiums will not be sufficient to pay for current losses when combined with the maturing assets SCIF currently holds. As we point out later, without a well-matched revenue stream and maturation schedule for assets, SCIF will be forced to take a loss on its long-term assets in order to meet short-term liabilities. This will lead to a significant surplus shortage and continued weakened surplus ratios in future years.

Recommendation #42– Level A

SCIF management, the CDI, and its appointed RBC plan manager develop and implement a depopulation plan which will assure reasonable rates for decreasing the premium volume, while maintaining adequate access for employers seeking coverage and maintaining underwriting profits.

Although the rates charged by SCIF will likely exceed those of private carriers, the costs will be affordable in the very essence of the definition. The rates will not exceed those needed to adequately cover anticipated losses of the insured pool.

By also implementing the requirement to pay 60% of surplus out of retained earnings, the insureds are guaranteed a dividend if their losses are better than anticipated.

The current SCIF senior management team is well qualified, with each member having 30 years of experience at SCIF. This experience lends credibility and builds trust in the staff of SCIF and serves leadership positions well. On the other hand, this long tenure of all the managers with experience only at SCIF tends to restrict the actions and application of outside management experience as SCIF attempts to right itself and emerge from the current financial challenges.

There could be added benefit to SCIF from bringing on additional management with outside experience as it works through the RBC plan with CDI. We understand SCIF has retained a management consultant to assist it in reviewing its current operations and to recommend changes to its practices and structure. That report should offer additional recommendations for SCIF to assist it in once again becoming the premier provider of workers' compensation coverage in California.

These management changes would also help allay some of the concerns expressed from competitors and other market players and encourage capacity from other carriers to enter the market. The more SCIF performance issues are addressed, the more confidence will be shown by competitors that the carrier will not go down to insolvency and the remaining carriers will be liable for current reserve insufficiencies.

Changing Nature of Competitive Balance

Regardless of the structure, the residual market should ideally comprise between 3 to 8% of the market in a healthy and competitive system. When the residual market grows beyond this range, it tends to affect the competitive nature of the market. This is due to several issues.

First, as the residual market grows, another segment of the market is decreasing. Secondly, the growth of the residual market indicates that there are pricing and exposure symptoms and pressures in the state that are not easily underwritten into adequate rates and pricing.

State Funds, as part of their public service role on creation, often are required to invest capital in providing strong loss control, safety and pre-loss services to minimize loss experience from the small, rural and new employers. Employers in the residual market pool of the state fund also benefit from this investment made by the state fund. These investments and other service commitments have made state funds attractive options to the competitive private marketplace.

Many newer state funds were formed due to the rapid growth of assigned risk pools in the early 1990's. States that formed funds which also address the assigned risk market segment growth in that time frame were Kentucky, Missouri, Hawaii, Maine and Texas.

Challenges Facing the Current Marketplace

If the situation does not improve in California, SCIF will remain the main market player for the foreseeable future. With SCIF remaining the largest player, you will see the reluctance of other carriers to increase their presence in the marketplace.

In addition, if the situation in California does not improve dramatically, we may see the market further restricted to the point where there are only two viable options for employers to provide workers' compensation coverage.

1. SCIF issues all policies, either through a competitive affordable policy or its market of last resort function.
2. Self-insurance either individually or as part of a self-insured group.

With the reduced options, California policymakers will have even more difficulty drawing carriers back into the market, as they will fear the possibility that regulators and legislators will ask the private market to secure the under-performance of SCIF, liquidated carriers, and the additional shortfalls from surety carriers that can come as a result of the increased stress in that market segment.

This will result in a de facto monopolistic market controlled by and only containing SCIF. SCIF already writes 50.5% of the written premium on a statewide basis. Many have suggested that this may be a reasonable alternative, and we will take a look at the system in comparison to current costs if California were to become a single-carrier state.

California Insurance Guaranty Association (CIGA)



California Insurance Guaranty Association (CIGA)

Assessments and Funding

Insolvencies have hit the California insurance market harder than most states. Since 1995, more than 25 workers' compensation carriers writing business in California have been placed in conservation or supervision or have been liquidated. Through a combination of local and national carriers, the California Insurance Guarantee Association (CIGA) is now responsible for more than \$85 million in monthly benefit payments to injured workers.

CIGA annual liabilities require a payout exceeding \$800 million a year to 40,000 injured workers. This is more than any private carrier or self-insured pays in California.

With additional carriers such as Home Insurance Company and Argonaut lining up to put additional pressure on CIGA, changes need to be made to the regulatory practices and administration to strengthen the financial ability of CIGA to manage its liabilities.

In mid-May of 2003, CIGA was given emergency authority from CDI to borrow from its non-workers' compensation accounts in order to meet cash flow obligations of benefit claims in this account. CIGA is also exploring the ability to sell long-term bonds to finance current liabilities. Other states, such as South Carolina and West Virginia, are considering similar bonding solutions for their entire workers' compensation systems. Connecticut has used this approach to fund its runoff of second-injury liabilities.

We recommend a number of administrative and legislative changes that would specifically affect CIGA's financial health and ensure that system stresses do not add to the market uncertainty.

The continued solvency and payment ability of CIGA is a major hurdle preventing additional capacity from coming to California. CIGA reported assets of \$977 million with ultimate liabilities of \$3 billion. With the premium assessment capped at an inadequate 2%, there is a realization that the current system will not be able to support the liabilities of CIGA and carriers. Entering California at this time will put their future capital at risk if they are asked to prop up the funding for the system. The current assessment rate raises about \$215 million per year. This is levied on \$10.8 billion in net premiums. Those assessments are ultimately passed on to employers as a surcharge on premiums, essentially socializing costs.

Recommendation #43– Level A

Provide more early warning notification from and cooperation with CDI and the CLO.
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California Insurance Guaranty Association (CIGA)



Although CDI correctly keeps its financial solvency opinions confidential, it needs to work more closely with the California Liquidators Office (CLO) and CIGA to provide early warning to those organizations so they can prepare for liquidation and transfer of claims as smoothly as possible. Accessing posted securities is a key factor in the CLO getting access to capital that it must then turn over to CIGA for claims payments.

Recommendation #44– Level A

Increase the assessment cap or eliminate the sunset provision on the CIGA premium assessment mechanism.

The 2% premium assessment mechanism provides \$215 million annually. With CIGA paying more than \$800 million per year, this leads to a significant funding shortfall of more than \$2 billion ultimate liability. An increase in this rate to 3% would provide an additional \$107 million annually, and an increase to 4% would provide an additional \$215 million at the current premium level, still not enough to stem the shortfall.

Eliminating the sunset date of 2007 for the CIGA premium assessment would reduce the future pressure to re-address at some point in the future. The downside to eliminating the sunset date is that the issue may drop out of the range of valuable review.

Recommendation #45– Level A

Change the premium assessment base to include standard premium rather than net written premium.

Keeping the assessment at 2% and increasing the base to standard premium of \$15.4 billion direct written premium, as reported to CDI in 2002, could raise an additional \$100 million per year. Standard written premium usually is defined as pure premium after the application of experience modifications and rating plan adjustments but prior to the application of premium discounts, policyholder dividends, other premium adjustments, expense constants, and other deviations.

Current CIGA assessments are applied to net premium after deductibles. This has the effect of restricting the assessment base to a smaller pool than most other state guaranty funds have.

Recommendation #46– Level A

In order to reduce the future liabilities against CIGA, implement a minimum net worth provision to exempt employers with net worth exceeding \$25,000,000 or \$50,000,000, from making third-party workers' compensation claims against CIGA.

California Insurance Guaranty Association (CIGA)



CIGA could still pay the claims on behalf of liable high-net-worth companies and directly bill the employer for benefits paid plus claims administration fee, or the high net-worth company could engage an authorized TPA to administer workers' compensation claims.

Thirty-one states currently have a minimum net-worth provision to help limit liabilities of their guaranty funds. Additionally, the National Association of Insurance Commissioner (NAIC) Post-Assessment Property and Liability Insurance Guaranty Association Model Act recommends that a minimum net worth provision is included for large value companies.

The rationale for this exemption is that larger companies tend to do more due diligence and have the assistance of agents or brokers in selecting and securing insurance coverage with more highly rated and financially stable companies that would not be as likely to fall into insolvency. Their exposure to and need to collect from CIGA would be less than employers with lower-rated insurance carriers.

A similar example of a similar action is that the Federal Pension Guaranty Corporation (PBGC) has invoked exclusions on certain types of enhanced pensions, as their ability to pay all liabilities has been eroded with company bankruptcies.

Further study should be done in conjunction with CIGA to assess the financial savings of these recommendations.

Penalties Against CIGA

Recommendation #47– Level A

Exempt CIGA from 5814 amounts for all future payments they make if the previous carrier was responsible for the delay.

Currently, CIGA and its TPAs are paying ongoing penalties as little as \$3 or \$10 per bill/payment. This is not a meaningful number to them and does not serve to deter future late delivery of benefits.

Reducing these payments will enhance the financial stability of CIGA to continue paying base claims amounts to injured workers. An alternative recommendation is to eliminate the medical going forward portions for CIGA. Case law needs to be codified out to change this interpretation as the Workers' Compensation Appeals Board (WCAB) finds CIGA responsible for this now.

We strongly believe that CIGA and its servicing TPAs should continue to be liable for penalties and 5814 for actions that were its responsibility. This practice would continue to appropriately hold CIGA and its contractors liable for non-compliance with their payment procedures.

California Insurance Guaranty Association (CIGA)



Recommendation #48– Level A

CIGA be exempted from self-imposing penalties on itself for late payments where they are unavoidable due to delays in transferring cases and initiating payments immediately after transfer from CLO.

We believe CIGA should remain responsible for penalties other than 5814 where its actions, or those of its agent TPAs, were responsible for a benefit delay to the injured worker. These amounts should be assessable and paid only after CIGA has had the opportunity to receive and set up the claims in a timely manner. We believe that this, along with the increased cooperation with CDI, will help to improve CIGA's financial status.

Recommendation #49– Level A

Codify language overturning current Workers' Compensation Appeals Board (WCAB) decisions (WCAB No. PAS 0023953), (WCAB No. LAO 778749 - Manzano), and (WCAB No AHM 075204 –Singh) finding CIGA responsible for previous practices of insolvent carriers.

Penalties against CIGA cost \$4 million per year. This recommendation will still hold CIGA liable for penalties due to its own actions or inactions. Continuing to saddle CIGA with the costs associated with previous carriers reduces monies available to fully fund other claimant benefit claims.

Other Observations About CIGA

While this report was not undertaken to review the operations of CIGA, we believe the following recommendations will help strengthen the operational ability of CIGA to more fully meet its liabilities.

Recommendation #50– Level B

CIGA and WCIRB should strive to provide loss-development information and work to provide ex-modifications for those employers who had policies with insolvent carriers to more accurately price their risks.

CIGA and the CLO should work to ensure their servicing TPAs provide loss information to WCIRB as a matter of service to the insureds as part of their contracting requirements. CDI can help to ensure compliance with this from servicing carriers. The need for experience modification factors for employers is key in a loss-sensitive insurance system and will more accurately reflect their true loss patterns.

California Insurance Guaranty Association (CIGA)



Recent actions taken by WCIRB have actually restricted and curtailed the issuance of experience modifications for businesses insured with certain carriers that have become insolvent. Experience modifications are a critical part of measuring and accurately applying an employer's individual experience to that of similarly situated businesses.

Without this additional needed discrimination, there are reduced economic incentives to employers to change their behavior related to safety. Additionally, there is less ability of carriers to accurately underwrite risks according to their expected losses.

Many carriers may assume that without a solid experience modifier, employers are not able to manage loss control and may encounter the highest possible rates when replacing coverage from insolvent carriers. Increased rates may add to an adverse incentive to non-insure for many employers.

Recommendation #51– Level B

CIGA retain and contract only with TPAs that meet or exceed the average score of the new DWC profile audit process, or alternatively, contract exclusively with TPAs that are in the 75th percentile of carrier rankings or higher.

Recommendation #52– Level C

CIGA initiate a process to standardize contract language for all TPAs to their benefit CIGA is now the largest volume purchaser of TPA claim contract services in the state, if not the country.

CIGA management staff may want to initiate additional performance measures to decrease overall administrative costs to a certain standard percent and review over time. Based on our discussions with CIGA, we believe they are already contemplating this change.

Review of CIGA Penalty Issues

The findings from this section will complement the findings from the research done by Frank Neuhauser on the DWC audits of insolvent companies. This section of the claims review was done to determine whether there were consistent poor claims practices exhibited by a non-random review of the cases CIGA is liable for. We reviewed the claims handling and file documentation practices of insolvent carriers prior to the transfer to CIGA and can comment on some of the general findings.

Introduction

California Insurance Guaranty Association (CIGA)



Hays staff met with representatives from CIGA and conducted a claim audit from May 5-7, 2003. The purpose of the audit was to review CIGA's statutory obligations relating to claim handling requirements and penalty issues, in order to determine whether CIGA should continue to be subject to penalties originally incurred by the respective insolvent carriers. A secondary goal of the visit was to obtain historical data and insight into identification of strategies that would increase the efficiency of benefit delivery to injured workers

CIGA pays approximately \$800 million in benefits to injured workers in California each year. In contrast, CIGA pays about \$4 million in penalties (assessed and self-imposed) each year. While it is certainly a significant amount of money, in relation to the whole, it is approximately one-half of one percent.

Methodology

We evaluated two basic types of penalty situations:

Penalties assessed on late payment to medical providers: regardless of the date that the original medical bill was paid late, there is a 10% penalty, plus interest, for every bill going forward. Penalties are paid to the claimant, not provider.

Penalties assessed for late payment of indemnity benefits. These penalties are payable at 10%, plus interest, to the injured worker and his/her attorney.

We were provided with a total of 62 selected open indemnity files to audit. We were provided authorization to review these files strictly in relation to claim handling practices and penalties, which occurred pre-liquidation. We are unable to comment on the claim handling practices of benefit payments made or penalties incurred directly by CIGA.

The files reviewed were a non-random sampling obtained by CIGA from Kemper, Intracare and Cambridge, three of the current third-party administrators utilized by CIGA. Some of the sampled files were handled in-house by CIGA adjusters. We only reviewed the file activity that pertained to the original insolvent carrier.

California Insurance Guaranty Association (CIGA)



Summary of Findings

Sixty-two claim files were reviewed, of which 43 or 69% were found to have had some type of penalty paid. Of the 43 penalized files, a total of \$804,384 was paid in penalties. This is an average penalty of \$18,706 per file. Of the files that were assessed penalties, 30% were medical-only, and 70% were indemnity lost-time cases.

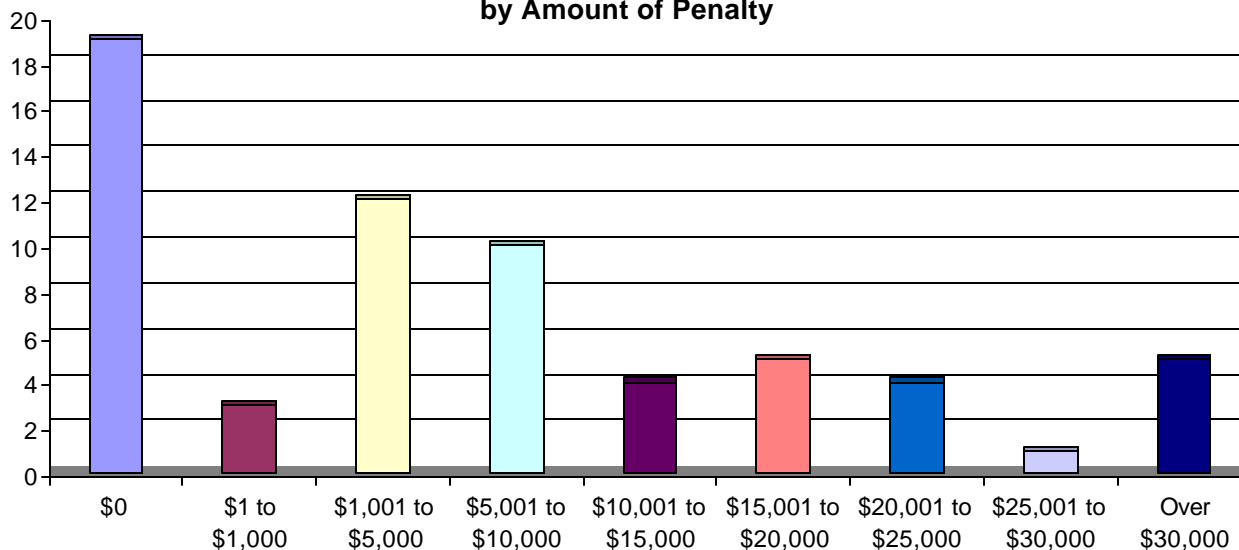
While these averages do not reflect the overall frequency and amount for the entire CIGA population, we believe this specific sample provides some insight to a general trend that CIGA and its serving TPAs have identified as a common occurrence in files they administer.

It should be noted that the data might be skewed by the existence of one particular file, which alone had a \$255,000 indemnity penalty. Removing this file from the data, the findings differ, primarily in the proportion of total indemnity vs. medical penalties paid. The distribution becomes more equitable at 56% indemnity and 44% medical.

Based upon conversations with CIGA personnel and our observations of the specific files we reviewed, penalties most often occurred during the insolvent carrier's rehabilitation process.

Chart 36

**Distribution of Penalty Assessments
by Amount of Penalty**



Self Insurance and Other Market Challenges



Self-Insurance and Other Market Challenges

Impacts From an Increase in Self-Insured Employer Options

California is seeing an increase in the number of applications for self-insured employer groups and will likely see a continuing increase in markets where employers have little pricing flexibility, low profit margins and high staff turnover (personal care companies, nursing homes, construction, retail associations, dealers and grocers). Staff turnover can undermine effective safety and return-to-work efforts key to managing workers' compensation liabilities.

The increase in premiums has caused some price-sensitive employers to consider a self-insurance option. The decision to become self-insured should be viewed from a long-term perspective as a means to manage long-tailed workers' compensation liabilities.

Thirty-five different groups are in the process of creating self-insured groups. Based on our discussions and published reports, 300 new groups could be formed in the next 3-5 years. These groups are generally joint and several liability programs, which leave individual members liable for the under-secured claims of group members who leave.

A challenge in California is that only homogeneous groups are allowed. This limits the pooling effect of insurance by leaving groups more vulnerable to other market risk factors that can adversely affect a single industry. Heterogeneous groups reduce specific industry risk to the pool participants.

While the increase in groups is a welcome additional option for insuring workers' compensation liabilities, we temper our enthusiasm and caution California regulators to carefully review the challenges that occurred in Florida, Kentucky, Oklahoma, Nevada and other states that saw unabated growth of self-insurance without the requisite level of regulatory oversight.

A danger in the rapid growth of group self-insurance is that the employer's decision to join or leave may be driven mainly by price sensitivity. As the market for workers' compensation will change in the future, employers will leave group self-insurance to return to the private market. The group self-insurance plans are not designed to have movement in and out of the group. With significant movement in and out of the group, it becomes very difficult to administer the group.

The challenge for regulators is to carefully screen all of the applications for self-insurance to verify that member employers are financially capable of funding a long-tailed exposure inherent in a self-insurance program.

Self Insurance and Other Market Challenges



The current market-pricing conditions may create adverse selection pressures and push employers with marginal financial ability to seek the ability to self-insure. This will likely put additional pressure on self-insurance regulation and the self-insurance guaranty fund.

Self-insurance security levels need to be set at adequate levels. Assuring that ongoing reserves and liabilities are sufficiently adequate and that the surety levels meet those liabilities is essential for the financial solvency of the self-insured participants.

Recommendation #53– Level A

Self-Insured Plans (SIP) look more closely at surety requirements prior to initial approval and acceptance and as part of an enhanced solvency monitoring program for all self-insured and group self-insured employers.

Many states that experienced large growth in self-insured groups saw competition from those groups against the traditional insurers and other risk-sharing groups. This had the effect of taking focus away from the safety and financial management issues that are so important for the success of groups.

This additional competition with the private carrier marketplace can drive the carriers to other lines or other states to deploy their capital. In both Oklahoma and Kentucky, private carriers redeployed their capital from workers' compensation to other lines of insurance.

States experiencing large-group self-insurance growth saw solvency challenges shifted to self-insured groups, many of which were not sufficiently capitalized to adequately fund future ultimate losses. If unchecked, self-insured groups tend to be cash-starved and require new members to bring in fresh capital. It works as well as social security, or as poorly as a badly implemented Ponzi scheme depending on the growth rate.

Recommendation #54– Level A

SIP should institute and require annual or biannual actuarial reviews of loss histories and ultimate loss liabilities.

Recent insolvencies have been under-reserved by as much as 45% according to the regulators and industry participants we spoke to. One-half to three-quarters of all self-insured cases taken over by SIP were under-reserved adding to the inadequate security position. Requiring enhanced actuarial opinions and the credit-rating mechanism that will come in with the new security arrangements should help to provide additional solvency testing for SIP.

Surety companies take a look at the ability of the subject company to remain solvent and meet their liabilities. A guide or warning sign for the SIP is if the subject company cannot obtain surety for securing their workers' compensation liabilities.

Self Insurance and Other Market Challenges



Recommendation #55– Level A

SIP may want to consider increasing deposit requirement levels to more fully protect remaining members against future insolvencies.

A potential downside to an increase in the number of self-insured groups is the need for adequate security in a time when surety companies are casting an ever more suspicious eye on the financial solvency and creditworthiness of their surety clients. The qualification process for approving surety is similar to many of the same criteria the new self-insured security pools will use to stratify their risks and price surety appropriately.

The right of first refusal to allow self-insurers to participate in a surety pool layer should not lie with the security fund, but rather with the regulator. The Self-Insured Security Fund and SIP would do well to carefully review the ability of current self-insured employers and newly applying groups to meet their liabilities.

The system admittedly was not set up to be fully funded. Current security shortfall estimates run close to \$60 million. We believe more attention should be paid to ongoing reserve liabilities, and deposits should be strengthened to fully fund most liabilities of self-insureds when they become unable to pay their ongoing liabilities.

Aggregate understated liability found in SIP audits increased from \$79 million in 1999 to \$125 million in 2002. This underscores the challenges in administering and properly reserving cases in California.

An additional outstanding shortfall from current estates is estimated at \$50 million. SIP and the self-insurers association face many of the same challenges that CIGA is now dealing with. We predict the self-insured market and security mechanism will continue to experience adverse development and worsening of conditions for the next few years. This will be exacerbated by the need to fund four separate accounts (two already in deficit status) in the new security rule environment being adopted by SIP.

The same challenges facing SIP from under reserving and securitization will now be borne by the self-insured employer pool as it began self-funding the securitization tools planned in the new solvency model.

We believe the new financial solvency tests from the proposed rules will improve this area. However, with the additional applications and expected growth in self-insured groups, we believe that SIP need to be more diligent than ever, as financial stresses that are present in the insured industry may seep over to the self-insured arena.

Without additional attention to the security, reserving practices and incurred loss development assumptions by self-insured employers, we are worried that the next crisis in the California market will be an increase in the bankruptcies of self-insured and group

Self Insurance and Other Market Challenges



employers. These could then adversely affect the financial solvency status of remaining employers as they are asked to fully fund this inadequate security level into the future.

Recommendation #56– Level C

Transfer Self-Insurance Plans from DIR Workers' Compensation to the Department of Insurance.

CDI and SIP have more in common with regulatory and approval responsibilities. The association with CDI may also enhance financial oversight, approval and monitoring processes SIP currently performs.

Reinsurance

Most primary carriers and self-insurers purchase reinsurance to cap their liability on individual occurrences and on their aggregate exposure. The reinsurance market has been suffering many of the same stresses as the primary market in California. In addition, reinsurers are seeing an increase in frequency of claims that in the past had not pierced retention levels. The increase in claims and payment frequency has caused retention levels and pricing to increase.

Aggressive re-insurance programs purchased by primary carriers in the late 1990's contributed to competing with inadequate rates. The failure of the Unicover re-insurance program, rapidly rising reinsurance premiums, and reinsurers restricting or not writing new policies have also contributed to the carriers deciding to limit their California premium volumes. This has created an access and affordability crisis for carriers and self-insured employers in California.

We will explore this reinsurance issue from two fronts:

- 1) The role that inadequately priced reinsurance and naïve capital from life and health reinsurers played in the carrier insolvency crisis.
- 2) The steps and actions that can be taken to ensure a readily available and accessible reinsurance market for primary carriers and self-insured employers.

The Role of Reinsurance

Reinsurance, the insuring of one insurance company by another, has an important place in the insurance marketplace. Among the many reasons primary insurance companies would buy reinsurance is to increase the capacity to insure more risks by transferring some of those risks to a third party, improve its loss ratio by transferring losses to a reinsurer for a smaller amount of premium than the losses transferred, expand its capacity to write a specific risk, which may present too large an exposure for one individual company, and improve its surplus position through a reflection on its balance sheet of anticipated investment income, which it may not be allowed to do otherwise.

In order for transactions to be treated as reinsurance for accounting purposes, there must be a transfer of risk. In addition to this risk transfer, most reinsurance programs result in the immediate recognition of anticipated investment income on a primary carrier's financial statements because the reinsurer's price reflects a larger dependence on investment income than the primary insurance pricing process.

The role of reinsurance in the California worker's compensation insurance marketplace in the late 1990s had significant impact on the cost and availability of workers' compensation insurance. The lack of a strong reinsurance market today has continued to

have a negative material impact on the cost of workers' compensation insurance and the ability of the California workers' compensation industry to respond to catastrophic losses.

The reinsurance segment that most affected the workers' compensation market in the 1990's was backed extensively by the life insurance industry. Although quantifying the impact is impossible because of the interlocking programs, sufficient evidence exists to understand and explain what was taking place at that time.

The original introduction of the type of product that was to cause an increase in competition because of unrealistically low pricing started innocently enough. The London reinsurance market introduced in the very early 1990s "carve out" products, which initially took the form of very high-excess reinsurance, often attaching at levels in the millions. For example, one such product covered occurrences above \$5 million and would have a limit of \$10 million for any one occurrence. Gradually, additional items were excluded or "carved out." Occupational disease exclusions and limits on the timeframe for reporting claims, so-called "sunset provisions," were added.

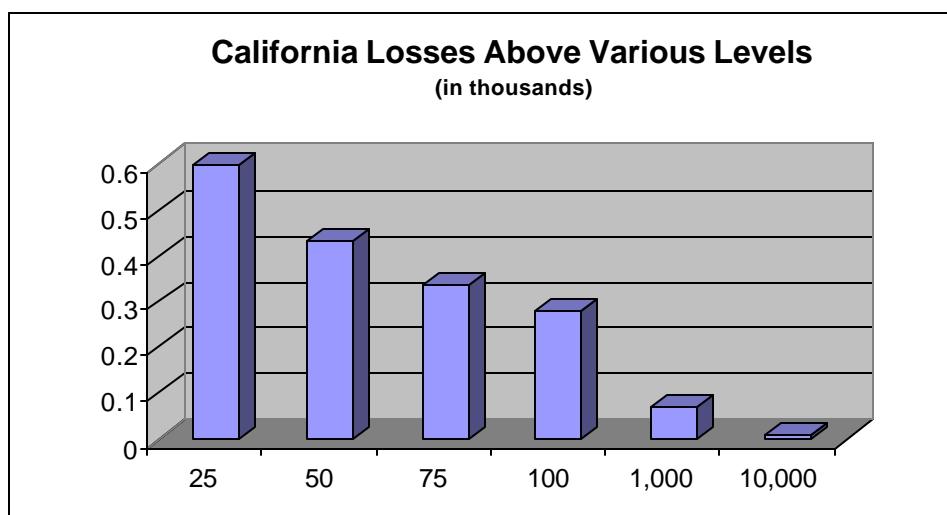
Because of the apparent similarity to medical and group health products, life insurance companies entered the field in the 1990s. Pooling mechanisms were established in which managing underwriters would accept workers' compensation into a reinsurance pool and distribute the risks among several life insurance companies who were acting as reinsurers. These life insurance companies in turn reinsured their exposure in London and among other life insurers, often including those that were involved in the initial pool. As a result of these intertwined relationships, it is impossible to accurately track and assess how much business eventually flowed to various companies.

The fact that life insurers pursued this market and developed these products is not surprising. They were very familiar with these ceding arrangements in their own life insurance marketplace. Ernst and Young reported that in 1991, 14% of face value life policies were ceded to reinsurance. By 2000, this number had jumped more than four-fold so that 62% of face value premiums ceded to reinsurers.

As these pooling mechanisms became more popular and the programs more convoluted, the pricing and terms and conditions became more liberal. The products had quickly become standard workers' compensation reinsurance programs with little of the "carve out" provisions remaining in effect.

The most popular programs during this period were low-retention specific excess reinsurance products; that is, the primary workers' compensation carrier would transfer all claim obligations above a specific amount, sometimes as low as \$5,000 or \$10,000. To understand the impact of this, the following table shows the amount of loss by layer for California:

Chart 37



The prices charged for layers above \$25,000 were often at levels that were 50% or less of what the traditional market would charge. As a result, the primary market players, domestic carriers in particular, were able to reduce their prices below the true costs of the insurance policies being sold.

As a result of these programs, California domiciled companies were able to compete at prices that did not match their true exposure. Such a condition was bound to unravel as became evident in the mid- and late-1990's.

The process of unraveling started as the life insurance industry's dependence on its own insurance had reached a critical state. Additionally, it became absolutely imperative to have this protection in place; and the London market became aware of the extent of the large disparity between risk absorbed and premium collected. As a result, contracts were non-renewed and in some cases rescinded. The domino effect moved swiftly through the industry.

Life insurance companies were quickly prohibited from writing workers' compensation contracts, London completely abandoned the market, and primary workers' compensation writers were faced with unreasonably low-priced books of business and the disappearance of a support system in the form of the life insurance industry.

Because of the disastrous results suffered by the workers' compensation reinsurers in this period, the traditional reinsurance community has been reluctant to return to this marketplace environment.

Add to this the additional uncertainty of major catastrophic events, such as the impact from terrorism or earthquake on workers' compensation exposures, and the price increases for reinsurance and increasing retention levels should not be surprising. These

stressors increase the reinsurance costs for primary carriers, their insureds and also self-insured employers.

Of the major reinsurance carriers interviewed for this project none have expressed a commitment to returning or expanding in this market. At best, some will participate but only in very limited programs. Much of this reluctance is because of the high average value loss shown in the ratemaking section of this report.

In their 1990 report, *Failed Promises: Insurance Company Insolvencies*, the United States House of Representatives indicated: "An insurer's ability to pay, its solvency, must be subjected to proper regulation on a continual basis, from the time premium payments are accepted until the time all insured events have been covered." We believe this same regulatory approach can assist in stabilizing reinsurance pricing and availability.

Pennsylvania Insurance Commissioner Diane Koken, a regulator intimately familiar with insolvencies, having overseen the rehabilitation and liquidation plans of Legion, Villanova and Reliance, testified recently before the National Conference of Insurance Legislators that past research has shown financially troubled insurers often have low-quality reinsurance and or uncollectible funds owed. We believe strengthening some of these recommendations will improve the quality of reinsurance available in the California market.

Steps and Actions to Ensure a Financially Stable and Accessible Reinsurance Market

Recommendation #57– Level A

Require primary carriers to retain a certain level (perhaps 25%) of their risk.

We saw examples of reinsurance arrangements that took retention levels down to \$5,000 per accident. With retention levels that low and average California claims costs running close to \$20,000 at that time, there was no way this pricing model could survive. There is no real risk retention to the carriers, and they are passing along the traditional risk transfer role to non-admitted reinsurers, neither familiar with workers' compensation, nor adequately underwriting the risks retained.

When carriers and self-insured employers utilize this method of managing risk, they tend to ignore the two basic insurance risk management tools: (1) adequate underwriting practices, and (2) workplace safety efforts. There is no incentive for these carriers to adequately manage their risks since they will be transferring the majority of the liabilities to another party.

Recommendation #58– Level B

Require primary carriers reinsurance be purchased through admitted carriers.

This is an additional requirement above and beyond current insurance code requirements (11690 and 922.4) giving a maximum allowance to carriers for reinsurance credits from accredited reinsurers.

Requiring that reinsurance carriers be licensed and admitted in California provides additional oversight and regulatory methods beyond accreditation for the CDI to monitor reinsurance practices in the workers' compensation field. With admitted carriers, the Commissioner would also have the ability to approve the form and policies utilized by workers' compensation carriers.

Recent efforts have been undertaken by major foreign reinsurers to ask NAIC to reduce collateral requirements from 100% to 50% depending on solvency criteria. While they indicate this would increase capacity and reduce prices to U.S. carriers, it would shift upwards of \$25 million in credit risks to U.S. carriers with an increasing uncertainty of ability to pay.

As one insurer indicated, reducing collateral and deposits under 100% leaves the carriers to ultimately depend on the good will of reinsurers to pay ceded claims. Experience shows this has failed in California, and allowing it again will put additional stress on carrier balance sheets and ultimately CIGA.

Recommendation #59– Level A

Repeal the ability of health insurers in California Insurance Code 11690 and 11691 to reinsure workers' compensation risks.

This specific authority may actually serve to encourage the entry of carriers with no workers' compensation reinsurance experience in providing coverage for risks they do not fully understand.

Under the certification and licensure process already in place, with deposit requirements, CDI would also be able to establish the reinsurance carriers understanding and experience in providing reinsurance for workers' compensation markets. Both these recommendations would help limit some of the naïve capital, which brought much of the solvency crisis to a head.

Recommendation #60– Level A

Require accredited reinsurers as defined in insurance code 922.4 to maintain a minimum financial rating issued by AM Best, S&Ps or Moody's.

Requiring a financial strength rating of A- or better would help ensure that the reinsurers conform to some of the same financial requirements that underlying primary carriers do. It would also add some additional market indicators self-insureds and carriers could use in weighing reinsurance products.

This recommendation adds another measure of credit quality to the oversight of admitted carriers. California already provides incentives for purchasing reinsurance through higher-quality carriers by requiring deposits for the ceded amounts to be posted with CDI.

Additionally, admitted carriers, in order to receive the full amount of reinsurance credit on their balance sheets, must purchase reinsurance through an accredited reinsurer (California Insurance Code 922.4) requiring submission to the California Department of Insurance.

Recommendation #61– Level B

CHSWC work with CDI and the Surplus Lines Association (SLA) of California to implement additional steps to strengthen the reinsurance marketplace.

Much work has already been done to tighten the financial oversight of excess and surplus lines carriers. Perhaps this expertise can be leveraged and replicated in strengthening some of the reinsurance oversight responsibilities resting with CDI. From their website, the SLA is described as:

In 1987, the SLA began a security review program limited to non-discretionary review of only foreign non-admitted insurers' security filings.

In October of 1993, California legislators passed Assembly Bill 865 (Insurance Code 1780.50). This Bill, which became effective January 1, 1994, codifies the responsibilities of a surplus line advisory organization and allows the Insurance Commissioner to delegate certain duties under a Plan of Operation. In addition to granting statutory recognition to the advisory organization, members and employees of the advisory organization were granted immunity while performing the delegated duties.

Recommendation #62– Level A

Create a separate and mandatory reinsurance pooling mechanism in which all workers' compensation carriers and self-insureds can participate.

Our last and perhaps most important recommendation in this area is to create a separate and mandatory reinsurance pooling mechanism under Insurance Code 11691. All licensed workers' compensation carriers, self-insured employers and public self-insured entities would participate in a California specific excess reinsurance pool.

This recommendation adopts the unique Minnesota model where reinsurance for workers' compensation must be purchased through a non-profit, self-funded pool. We believe the study and adoption of this model will lead to a stable, accessible and affordable market for reinsurance going forward in the California workers' compensation market.

If this recommendation were adopted, the previous four recommendations under the reinsurance section of this report would be unnecessary. We believe this last recommendation, while important, will require significant study and design before being implemented.

The establishment of an exclusive state reinsurance fund was one of the major recommendations coming out of an 18-month study completed by the Minnesota Workers' Compensation Study Commission. This was done in a difficult market with increasing premiums and retention levels for reinsurance similar to what California insurers and self-insured employers have faced for the past two years.

That study indicated: "The commission believes that a state reinsurance fund would alleviate the shortage of commercial reinsurance and reduce the burden on insurers and self-insurers of long-term escalating claim liability...its expenses might be less and investment income available from reserves might also reduce costs to employers."

Indeed, 24 years after creation, the Minnesota Workers' Compensation Reinsurance Association (WCRA) has returned more than \$1.23 billion in excess surplus, paid more than \$356 million in excess claims, and fully funded future liabilities while collecting \$1.01 billion in premiums.

We believe this recommendation will ensure access to stable and affordable reinsurance and will go a long way to encouraging insurers to re-enter and expand in the California workers' compensation marketplace.

In order for this tool to work, all carriers and self-insured employers, even public self-insured employers who currently forego reinsurance, would be required to participate to create an adequate pooling mechanism for all California workers' compensation experience.

By requiring all players in the system to purchase reinsurance through a pool, a number of important aspects are handled to lessen the burden on employers and carriers in the California market. This model is similar to, but simpler than the recent changes made to the self-insured security fund guaranty and surety-pooling model.

1. Ensuring there is adequate capacity of reinsurance.
2. Ensuring reasonably priced and affordable reinsurance.
3. Dollars spent for reinsurance on an annual basis can be invested in and controlled by California policymakers. This strengthens the requirement currently in place under Code 11691 and 922.6 and 7.
4. California experience only sets the pricing for reinsurance.
5. Reinsurance could be provided to statutory levels for all policyholders.
6. Retention levels can be set flexibly depending on a company's risk appetite.
7. Coverage from terrorism is authorized by the 2002 federal Terrorism Risk Insurance Act, which specifically allows participation from workers' compensation risk reinsurance pools in the federal pool.

The California Commissioner of Insurance is interested in this model as are self-insurers in Oregon who see this as a flexible and cost-effective tool to provide reinsurance at affordable levels to their members. Legislation has been introduced for consideration in the next legislative session (Senate Bill 3 – 2003 Regular Session).

Many states are exploring similar public risk-sharing models like this for a solution to their property insurance challenges for flood, wind and earthquake. Louisiana is proposing a change to their FAIR plan allowing excess reserves to accumulate without taxation (2003 HB 1788.) This helps to increase the capacity of catastrophic and reinsurance coverage. Florida implemented a similar plan earlier in 2002. California itself has a model similar to this for spreading earthquake risk for homeowners through the California Earthquake Authority.

This will allow self-insured employers and groups to access affordable and available reinsurance. Access to reinsurance tends to be a larger challenge for individual and group self-insurers than it is for national insurance carriers. We believe this model will substantially benefit self-insured employers. Self-insureds are the group pushing this model in Oregon this year.

Access to and affordability of reinsurance to primary carriers were a large factor in and concern for the California market. We believe these recommendations will provide a stable and accessible market for all primary carriers in California. During the past three

Reinsurance



years, reinsurance premiums have seen annualized increases approaching 100% with significant increases in retention levels.

Future Studies

During the course of gathering information for and discussing issues with system participants, a number of additional topics came to light. While they are interesting and likely warrant additional study, they are beyond the scope and/or resources of this project. We do believe identifying these areas would be helpful for CHSWC and interested parties.

According to a recent analysis by CWCI, doctors who treat higher caseloads of workers' compensation patients on average provide more cost-effective treatment, when controlled for same medical procedures, than providers that treat low-volume caseloads.

38.5% of providers treating workers' compensation cases see only one case per year. 90% of all providers see one or no workers' compensation cases per year.

Recommendation #63– Level C

A study to determine if these high-volume doctors provide satisfactory care, earlier return-to-work, or reduced average wage loss would be instructive in designing medical access and treatment protocol.

This is another rationale used for requiring certification of doctors. Do doctors who have more familiarity with occupational health provide more ratable and accurate disability reports for use at DWC? Current legislation is being considered to address this issue.

Recommendation #64– Level C

Determine if there is a benefit to controlling certification, registration and training of doctors for disability opinions who treat workers' compensation patients.

Recommendation #65- Level B

Study how consistently DEU applies the rating schedule and mechanism for various types of injuries and disabilities.

A blind rating test should be given to raters to determine the inter-rating consistency between raters for the same report and rating consistency in the same rater with identical reports with details changed. DWC indicates their ratings are consistent. Are ratings accurate and within an acceptable range of divergence? Has there been an expansion or constriction of PD ratings creep over time?

With consistency and unpredictability of the rating methods cited by many as a challenge to the system, this would be an important area to research.

Recommendation #66– Level C

Perform a study to determine what, if any, agency theory effect and costs and actions are taken by insolvent carriers as they near bankruptcy.

A negative agency effect and higher long-term costs can be observed in companies whose managers take riskier steps to right the ship as a company becomes more and more financially shaky. They are willing to take larger chances with shareholder equity, as there is less risk of additional downside and the hope that they can gamble their way out of the crisis with one big win. This can also be seen with managers that have stock options under water.

Do managers of carriers faced with rehabilitation or insolvency take larger risks (underwriting more risky business, looking for cash flow at the cost of solid underwriting practices and reserve practices or claims payment practices)? Some of these theories have been advanced in direct action cases from policyholders against carriers for their lawsuits.

Recommendation #67– Level B

Perform a study to determine whether the implementation of treatment protocols, fee schedules and other cost-control mechanisms in other jurisdictions restricted access or quality of care provided to injured workers.

These are concerns raised by providers and advocates for employees. To-date, studies done in Rhode Island and Minnesota have not found any restrictions to care or reduction to quality.

The Workers' Compensation Health Initiative administered by the University of Massachusetts Medical School (UMASS) has identified a number of tools and matrices for determining quality and access of care for injured workers. Many of these have been developed by URAC, and the UMASS developed Worker Injury National Survey (WINS). CHSWC voted in late 2001 to conduct a WINS survey in California. We endorse this plan to help monitor access and health care satisfaction as medical cost containment tools are implemented.

The objective performance measures can be used to help create treatment parameters and the employee satisfaction with care provided under parameters or through HCOs. These measures can be found on the UMASS website and were covered at the 2003 CHSWC Medical Colloquium.

Recommendation #68– Level B

Perform a study to determine the feasibility of segregating and selling off the old claims liabilities of the CIGA and SCIF.
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Some states (Arizona, Montana, West Virginia, Utah) have explored this option in the wake of market challenges as a way to define and segregate the old liabilities and start fresh with new insolvencies for the market going forward. This tends to allay many of the fears market players are expressing about the lingering liabilities of both insolvent carriers and for the older, under-reserved portion of SCIF claims.

The California self-insurers are doing one method of this by segregating out old liabilities for the existing shortfall in surety and going forward with a new solvency guaranty program for new liabilities incurred in the future.

Evaluation of Current and Future Trends

There are several future national trends in workers' compensation reviewed in this section. It is important to note that these overall national trends are affected to a large extent by the challenges facing the California system. These issues will affect the future costs and coverage of workers' compensation programs nationally and in California.

1. Integration of benefits.
2. Data privacy.
3. Terrorism.
4. Financial crisis and investment environment.
5. Federalization of workers' compensation programs.

The issue of integrating occupational and non-occupational medical and disability coverage has been discussed over the past decade. There have been some pilot projects in Arizona, California and Connecticut to explore the feasibility and process of integrating occupational and non-occupational coverage. These studies have highlighted several significant roadblocks to integrating these distinct programs.

One significant issue is the belief that treating both injury and illness cannot occur in a similar fashion for both medical and disability issues. In some cases, the treatment process is more aggressive and more costly to decrease lost time and to ensure an early return-to-work. The reconciliation of this belief has proved a hurdle for treatment parameter design and for integration benefits. Progress has been slow in finding successful models of integration, and some of these same challenges have presented themselves in the 24-hour coverage debate.

The future of integrating occupational and non-occupational programs will be driven by the costs of the current separated systems and the potential benefits of combining these programs. There is renewed focus on these programs due to the continued rising costs and complex treatment programs that are disjointed and uncoordinated.

We also see that regulatory pressure will be applied to find more efficient and effective ways to deliver these services for the benefit of both injured and ill citizens. We can foresee that regulators will take a more active role in this process to engage all parties to find solutions to the challenges of delivering services more cost effectively and efficiently for all injuries and illnesses.

Recommendation #69– Level C

CHSWC study and facilitate discussions on methods to integrate occupational and non-occupational medical and disability programs.

Another trend in the present and future centers around data privacy issues. The California payor, provider and patient systems have both the California medical privacy and HIPAA

issues to contend with. The medical privacy issues are important and necessary to have in a state-of-the-art workers' compensation system.

It is important to find ways to manage data privacy issues between differing state and federal legislation to assist the workers' compensation system in California to operate without conflicting and confusing data privacy rules. Having a clear set of standards for claim payers is important for compliance and efficiency of the system.

Recommendation #70– Level B

CHSWC study ways to develop fair and clear standards for data privacy in the California workers' compensation system.

Terrorism is another issue in the future of workers' compensation in California and the country. The Terrorism Risk Insurance Act of 2002 (TRIA) was signed into law in November of 2002; however, there remain significant questions.

TRIA is a short-term solution and is scheduled to expire in 2005. If TRIA is allowed to expire, insurers will be left without a backstop in the event of another terrorism attack. Workers' compensation acts in all states do not allow carriers or self-insureds to exclude terrorism. The expiration of TRIA without any additional backup in place will have the potential to negatively affect workers' compensation in the future.

There are several challenges even with TRIA in place. The most severe of those is finding adequate re-insurance coverage at affordable pricing for carriers and self-insureds. TRIA only covers foreign terrorism and not domestic terrorism. This does place a burden on the system in the event of a domestic terrorism act.

Another consideration is the effect on the guaranty fund and its assessments if a carrier or self-insured becomes insolvent due to losses from terrorism. These are significant economic pressures to the workers' compensation system today with TRIA and in the future without TRIA.

Recommendation #71– Level C

Form a system-wide committee to develop strategies to deal with workers' compensation issues in the event of a terrorism act in California.

Another trend that will become more prevalent as challenges in state systems continue is the concept of federal regulation of workers' compensation. The growth of companies that have multi-state operations and the continuing growth of a more global economy will put more pressure on state workers' compensation systems to address issues that extend beyond the traditional state perspective.

The current issues that are in the forefront today are carrier liquidations, other state coverage issues, global commerce and differing regulatory systems. Carrier liquidations have had a large impact on California and the guaranty fund. Several of the carrier liquidations are of carriers domiciled in other states (Reliance, Legion, Home, etc.). The regulators in the other states are dealing with issues germane to their states and have little incentive to consider how their processes and decisions affect other states and their guaranty funds.

Recommendation #72– Level C

CHSWC study the rationale behind federalizing the workers' compensation system in order to understand the impacts of federalizing workers' compensation would have on California.

Impact of Evolving to a Single-Payor State

Comparing California to single-payor, exclusive state fund models (North Dakota, Ohio, Washington, West Virginia and Wyoming) is not a simple exercise. Each state has a 90-year history of a mature workers' compensation system, which was created with different goals and which evolved in response to different incentives and pressures over the years.

Important differences in the cost structure, compensability, exclusions, waiting periods, mix of benefits, industry mix and benefit levels are present in almost every comparison we can do with California.

In the following table, we select some important metrics to provide some comparison for California with exclusive states. This data was selected from a variety of sources including the 2002 U.S. Chamber of Commerce Analysis of Workers' Compensation Laws and the 2002 U.S. Department of Labor State Workers' Compensation Administration Profiles.

Table 4

State	Covered Workers (Millions)	Max Rate (Weekly)	Waiting Period	Physician control	Premium per \$!00 payroll	National Cost Rank	Agency Size	Staff/ 1000 Worker
California	14.7	\$602	3 days	Employer	5.23	1	847	0.058
North Dakota	0.3	\$516	5 days	Employee	1.24	51	225	0.750
Ohio	3.9	\$628	7 days	Employee	2.89	13	2839	0.728
Washington	2.7	\$538	3 days	Employee	1.65	45	2000	0.741
West Virginia	0.7	\$491	3 days	Employee	2.53	23	554	0.791
Wyoming	0.2	\$527	3 days	Employee	1.97	38	140	0.700

Even with a move to single payor status, system costs in California, which we have focused on throughout the rest of the report, still need to be changed and controlled in a more predictable manner. Without those controls, there will be no cost savings by moving to a self-funded system. If a move were implemented, the initial startup costs for additional office space, equipment, staff, technology and reserve buildup would be enormous.

A couple of interesting notes from the data points above are:

- California has almost four times the covered workers of the largest single-payor state, Ohio.
- Even without the social insurance mentality of many single-payor states, California average premium per \$100 payroll is 80% higher than the next highest state, Ohio.
- Most exclusive states maintain a staffing level of .75 per thousand workers. 13 times the current level of California

When looking at the possibility of moving to a single-payor model, one needs to understand that rates in exclusive states have also seen a significant increase in rates during the past five years. Rates in Washington state have gone up 29% in the last year, a reduction from the ratemaking recommended average rate increase of 41%.

West Virginia, another single-payor system, has seen a challenge to its reserving practices and is under-reserved by \$3.5 billion dollars. Since the state of West Virginia is technically liable for the operations of the West Virginia State Fund, they are wrestling with mechanisms to fund and ensure the ongoing health of the State Fund. Those shortfalls as well as administrative challenges in delivering benefits, will also lead to significant rate increases for employers over the next few years.

One method being considered is to issue low-interest rate bonds and deposit that money as partial funding for the \$3.5 billion in unfunded liabilities. California could also consider the issuance of bonds to fund the under-reserved portions of SCIF and unfunded liabilities at CIGA. There will likely be many objections to SCIF being given the proceeds from a public bond sale. We understand CIGA is already proposing that mechanism for funding current cash flow challenges.

While North Dakota has experienced relatively stable rates to policyholders over the past few years, the NDWC was significantly under-reserved by more than \$250 million which led to a need for strengthening reserves to the tune of \$400 million over several years. North Dakota passed significant reforms to its workers' compensation system to focus resources on the employees and employers of North Dakota.

Ohio, another single-payor state, in May 2003, eliminated policyholder rate rebates and reductions given every year since 1996. Since then, more than \$9.3 billion has been returned to policyholders through rate rebates. Operational practices indicate surplus is to remain at \$3 billion. The current balance now stands at \$200 million, a shortfall of \$2.8 billion.

If reserve developments continue on a negative trend, rates will need to be increased in order to make up the current and larger future deficit.

We were asked to more closely analyze the Washington state system and do a short comparison to determine whether the single-payor model there may have some lessons and benefits for California. This comparison is done at a high level, and further in-depth study requiring resources beyond the scope of this project is needed to more fully analyze the steps needed to transfer to an exclusive state fund model.

We gathered and compared information available from the California and Washington state workers' compensation websites, the US Department of Labor October 2002 State Workers' Compensation Administration Profiles, and the US Chamber of Commerce 2002 Analysis of Workers' Compensation Laws.

Similarities

Both California and Washington require all employers, without exception, to carry workers' compensation insurance. There are no small employer exemptions. Workers from non-compliant employers are covered by the uninsured employer fund in California, and by the Department of Labor and Industries in Washington, which then goes after non-compliant employers for past-due premium.

Attorney fees for both states are paid out of the employees benefit awards. Both states cover the same range of injuries and accept occupational diseases to the same general extent.

Self-insuring workers' compensation liabilities is an option for employers in both states; however, group self-insurance is available only for public entities in Washington.

There are cost-of-living adjustments in both states allowing for inflationary increases to limit the benefit erosion over time.

Differences

In contrast, there are more differences than similarities between the states. The main differences are (1) funding and administration of benefits, (2) minimum benefit rates, (3) administration of the PPD system, (4) compromise and release agreements, and (5) choice of doctor.

1. Washington is the only state that does not use payroll as a base for premium. Instead, it utilizes man-hours worked as a premium base. This has the effect of increasing premium costs for heavily unionized states with high hours and hourly rates.
2. Washington collects its premium by a payroll tax, which includes unemployment and reemployment compensation and is borne partially by the employee. The premium is not solely a funding mechanism for the administration of the system. Although 25% of the premiums go for administration, the remaining 75% goes for benefits to workers.
3. Minimum TT benefit rates for California are \$126 weekly compared to \$42 for Washington. Some policymakers believe a high minimum rate provides incentives for increased claiming frequency, when high minimums may actually be higher than wages earned. We did not have a chance to determine whether studies support that belief.
4. The PPD system in Washington is based mainly on impairment ratings only. While they are assessed and recommended by the treating physician, the payor, in this case the Department of Labor and Industries, makes the ultimate decision and

- payment on the PPD award. Interestingly, average Permanency awards across a selection of common disabilities are significantly higher in Washington. On average, they are more than twice the impairment amount in California.
5. Compromise and release in Washington are relatively rare, and cases are easily reopened after closure. This has the tendency to string out claims and create a difficult time for reserving cases, although nowhere near the unpredictability in California.
 6. Choice of doctor is an almost universal right of employees in Washington, and although they can change doctors, there needs to be a pre-approval from the Department.

We find no compelling reason for consolidating and socializing the costs and challenges of the current workers' compensation system crisis onto a state budget that is in serious financial deficit status. Transferring the problems of the insured system onto the state could add another \$12 to 13 billion in under-reserved shortfalls onto the current state liabilities.

This issue, studied in the 1992 Rate Oversight Committee report, was not endorsed at that time either.

Recommendation #73– Level A

Do not move the California workers' compensation market towards a single-payor state.

Analysis of Alternative System Designs

Significant exemptions could also be enacted in the California code. In addition to current exemptions for independent contractors, volunteer and household workers, California could consider enacting changes in coverage requirements to exempt employers with fewer than a stipulated number of employees.

Twelve states, Alabama (<5), Arkansas (<3), Florida (<4), Georgia (<3), Michigan (<3 in most cases), Mississippi (<5), Missouri (<5), New Mexico (<3), North Carolina (<3), South Carolina (<4), Tennessee (<5), and Virginia (<3), allow employers with less than those stipulated numbers to opt out of compulsory insurance requirements in most cases.

In this case, it would allow carriers and especially SCIF, which has not been able to exercise that ability effectively, to drop policies that do not provide underwriting profits. Most of those accounts are smaller premium, smaller employers who will likely have a hard time finding replacement coverage. In order to address this challenge and reduce the incidence of uninsured employers, we have recommended some steps to create a separate residual or Assigned Risk Plan.

An alternative solution is to place all employers, with fewer than three full-time equivalent employees, and those with experience modifications exceeding 1.5 or those in higher- hazard classes into a separate assigned risk mechanism that would pool the poor risks. Some states allow employers who demonstrate good losses to receive scheduled dividends or rate discounts after a certain period of time. Other states have formal depopulation plans to assist those employers to obtain private coverage.

This would obviously reduce expenses, claims and overall system costs, but would significantly reduce protection for both employers and employees in the no-fault workers' compensation system. Most affected employers would be those with less than \$1000 annual premium.

Leadership Summit

The Recent Medical Colloquium hosted by CHSWC at UCLA provided significant insight for a number of industry participants and was seen as a success to engage policymaking discussion.

Recommendation #74– Level C

CHSWC, in conjunction with DWC, WCIRB and CDI, should coordinate and host a CEO summit for insurance carriers, employers, employees, self-insured employers, legislators and possibly reinsurance and surety companies.

We believe this would provide excellent insight and input from parties actually participating in the system and allow them to comment on these and other recommendations for systemic changes.

Summary

We have combined and prioritized the recommendations from the main body of this report. We believe those higher recommendations (A level) will have the most positive system impact if implemented in a timely manner. Similarly, those denoted as B level will have more impact than C level recommendations.

Our intent is to segregate recommendations to focus attention and resources where they can provide the largest impact in the coming months. We have also separated each level of the prioritized recommendations into those that require legislative action and those we believe can be implemented in the current regulatory environment through administrative and rule changes.

Level A - Administrative Changes

Recommendation #1 – page 25

CDI should take a more proactive role in requesting justification for scheduled rate credits and their approval.

Recommendation #4– page 27

CDI regulatory emphasis should be placed on solvency regulation. That emphasis should be on the liquidity aspects of an insurer. Also see Recommendation #12.

Recommendation #11– page 53

Consider adopting a more consistent and predictable permanency schedule that can be applied more consistently to targeted appropriate workers.

Recommendation #30 page 74

Fully fund and fill the administrative support staff as recommended in the RAND study *Improving Dispute Resolution for California's Injured Workers*

Recommendation #32– page 75

Implement an anonymous and random judicial survey or feedback process for participants in the administrative law dispute resolution system.

Summary and Recommendations



Recommendation #34– page 75

Implement and enforce a stricter and more consistent interpretation of filing requirements, timelines, and supporting documentation on both parties.

Recommendation #36– page 80

Distinguish and track the results from the residual market or “Assigned Risk” policies from those that are competitively written by SCIF.

Recommendation #42– page 84

SCIF management, the CDI, and its appointed RBC plan manager develop and implement a depopulation plan which will assure reasonable rates for decreasing the premium volume, while maintaining adequate access for employers seeking coverage and maintaining underwriting profits.

Recommendation #43– page 87

Provide more early warning notification from and cooperation with CDI and the CLO.

Recommendation #53– page 95

Self-Insured Plans (SIP) look more closely at surety requirements prior to initial approval and acceptance and as part of an enhanced solvency monitoring program for all self-insured and group self-insured employers.

Recommendation #54– page 95

SIP should institute and require annual or biannual actuarial reviews of loss histories and ultimate loss liabilities.

Recommendation #55– page 96

SIP may want to consider increasing deposit requirement levels to more fully protect remaining members against future insolvencies.

Summary and Recommendations



Level A - Legislative Initiatives

Recommendation #2– page 26

Reduce or eliminate the use of all rate credits for the California market.

Recommendation #3– Page 27

California may wish to review reducing the rate oversight and approval mechanisms and procedures at CDI.

Recommendation #7– page 48

Immediately adopt fee schedules for all treatment segments to a 100 or 120% level of Medicare. This may be a reasonable place to start. CHSWC has already done background work to identify this as an effective method to control medical costs

Recommendation #8– page 49

Adopt meaningful treatment guidelines for all areas of the body. The IMC and DWC are currently exploring the feasibility of creating and implementing such guidelines on an acute phase.

Recommendation #9– page 51

Require treatment plans be developed for injuries and require showing of cure AND relief from the treatment and that objective improvement is planned and progress is shown during approved treatment plans.

Recommendation #17– page 60

Adopt a tiered, one-time only penalty system on each medical bill paid late, rather than a running penalty based on what could have been only one late payment.

Recommendation #19– page 60

Adopt a tiered, one-time penalty structure should be adopted for indemnity late payments replacing the current ongoing/rolling 5814 fee.

Summary and Recommendations



Recommendation #20– page 60

Penalties should not be assessed on future benefits that are paid in an appropriate, timely manner.

Recommendation #29– page 73

Implement uniform billing formats and electronic payment systems to more closely replicate with other payor billing system arrangements.

Recommendation #37– page 81

Create a separate and distinguishable account within SCIF for the purposes of monitoring, underwriting and pricing those risks written as a residual market.

Recommendation #40– page 83

Regulate the State Fund under a minimum rate law type provision with mandated minimum premium rates based on loss-cost factors in the range of 1.33 to 1.5 times WCIRB's loss cost.

Recommendation #41– page 83

Require that the State Fund pay up to 60% of its annual earned surplus to its policyholders in the form of dividends.

Recommendation #44– page 88

Increase the assessment cap or eliminate the sunset provision on the CIGA premium assessment mechanism.

Recommendation #45– page 88

Change the premium assessment base to include standard premium rather than net written premium.

Recommendation #46– page 88

Summary and Recommendations



In order to reduce the future liabilities against CIGA, implement a minimum net worth provision to exempt employers with net worth exceeding \$25,000,000 or \$50,000,000, from making third-party workers' compensation claims against CIGA.

Recommendation #47– page 89

Exempt CIGA from 5814 amounts for all future payments they make if the previous carrier was responsible for the delay.

Recommendation #48– page 90

CIGA be exempted from self-imposing penalties on itself for late payments where they are unavoidable due to delays in transferring cases and initiating payments immediately after transfer from CLO.

Recommendation #49– page 90

Codify language overturning current Workers' Compensation Appeals Board (WCAB) decisions (WCAB No. PAS 0023953), (WCAB No. LAO 778749 - Manzano), and (WCAB No AHM 075204 –Singh) finding CIGA responsible for previous practices of insolvent carriers.

Recommendation #57– page 101

Require primary carriers to retain a certain level (perhaps 25%) of their risk.

Recommendation #59– page 102

Repeal the ability of health insurers in California Insurance Code 11690 and 11691 to reinsure workers' compensation risks.

Recommendation #60– page 103

Require accredited reinsurers as defined in insurance code 922.4 to maintain a minimum financial rating issued by AM Best, S&Ps or Moody's.

Recommendation #62– page 104

Create a separate and mandatory reinsurance pooling mechanism in which all workers' compensation carriers and self-insureds can participate.

Summary and Recommendations



Recommendation #73– page 116

Do not move the California workers' compensation market towards a single-payor state

Level B - Administrative Initiatives

Recommendation #5 – page 29

Make every attempt to continue gathering experience loss information from insureds that were with bankrupt carriers.

Recommendation #12– page 55

CDI must change the emphasis in its regulation for solvency, moving from a passive monitoring and pre-approval of rate processes to an active analytical approach centering on liquidity.

Recommendation #13– page 56

Consider liquidating companies earlier in the rehabilitation process or severely restricting the time line for rehabilitation to maximize the security and deposits for use by the guarantors.

Recommendation #14– page 57

CHSWC and CDI form a working group to identify and address the factors in California that are contributing to any reserve deficiencies in the California marketplace. Include members from WCIRB and NAIC, as well as members from the Garamendi Advisory groups.

Recommendation #22– page 63

CDI should consider offering an initial training certification program for all California workers' compensation adjusters.

Recommendation #23– page 63

CDI work to develop a training program specifically for newly hired claims adjusters. If the program is successful, CDI could consider different levels of certification for different positions (claims assistant, claims adjuster, senior adjuster, supervisor, manager, etc.).

Summary and Recommendations



Recommendation #26– page 67

Study the direct action lawsuits to better understand the impact they have on ratemaking and reserving adequacy for the industry. Determine if removing the direct action lawsuits is justified in the workers' compensation system.

Recommendation #27– page 72

DWC adopt a reserve review component to its claims audit process and make referrals to CDI financial auditing sections when warning signs are detected.

Recommendation #28– page 73

The practices and procedures identified by DWC in the annual profile audit of the highest scoring carriers and TPAs be highlighted as “best practices” for utilization by the remaining industry participants.

Recommendation #31– page 74

Increase focus on training and communication of administrative law judges.

Recommendation #50– page 90

CIGA and WCIRB should strive to provide loss-development information and work to provide ex-modifications for those employers who had policies with insolvent carriers to more accurately price their risks.

Recommendation #51– page 91

CIGA retain and contract only with TPAs that meet or exceed the average score of the new DWC profile audit process, or alternatively, contract exclusively with TPAs that are in the 75th percentile of carrier rankings or higher.

Recommendation #61– page 103

CHSWC work with CDI and the Surplus Lines Association (SLA) of California to implement additional steps to strengthen the reinsurance marketplace.

Summary and Recommendations



Recommendation #65- page 107

Study how consistently DEU applies the rating schedule and mechanism for various types of injuries and disabilities.

Recommendation #67- page 108

Perform a study to determine whether the implementation of treatment protocols, fee schedules and other cost-control mechanisms in other jurisdictions restricted access or quality of care provided to injured workers.

Recommendation #68- page 109

Perform a study to determine the feasibility of segregating and selling off the old claims liabilities of the CIGA and SCIF.

Recommendation #70- page 111

CHSWC study ways to develop fair and clear standards for data privacy in the California workers' compensation system.

Level B - Legislative Initiatives

Recommendation #6- page 30

The California Legislature should consider expanding the ability of WCIRB to explore collection and utilization of self-insured and public employer loss data to more fully capture the loss experience of the entire California marketplace.

Recommendation #10- page 51

Consider requiring pre-approval for treatment after a maximum medical improvement status is reached as determined by the treating physician.

Recommendation #21- page 61

Summary and Recommendations



As an alternative to the 5814 structure, a stair stepping penalty structure similar to that used in many states should be adopted.

Recommendation #35– page 76

Adopt a presumption of fairness for compromise and releases when all parties are represented by licensed attorneys.

Recommendation #38– page 81

Create a separate Assigned Risk Pool (ARP) outside SCIF administered on a contract basis. This can be managed by a separate company, or can be conjoined with other state assigned risk pools in the National Workers' Compensation Reinsurance Pool

Recommendation #39– page81

Create a FAIR (Fair Access to Insurance Requirements) plan. Many states utilize this to ensure access to property insurance for business and homeowners or auto policies.

Recommendation #58– page 102

Require primary carriers reinsurance be purchased through admitted carriers.

Level C - Administrative Initiatives

Recommendation #15– page 57

CDI look more closely at reserving and claims practices of the insolvent carriers to determine if there were changes in the reserving practices at some point prior to the insolvency that could have led to the faltering financial condition of the carriers.

Recommendation #16– Page 57

CDI conduct a close review of the management structure, experience and background as part of its solvency oversight and approval for new carriers.

Recommendation #24– Page 64

Summary and Recommendations



DWC Audit unit monitor and publish average lost-time and medical-only caseloads by audit location. This can be incorporated into the profile audit process designed by CHSWC and implemented by DWC.

Recommendation #25– page 67

As a best practice, require that carriers adopt an electronic reserving program to assist in timely, accurately and adequately setting reserves consistent with state-specific system experience.

Recommendation #33– page 75

Develop and adopt a judicial code of conduct in conjunction with the recommended judicial survey program.

Recommendation #52– page 91

CIGA initiate a process to standardize contract language for all TPAs to their benefit CIGA is now the largest volume purchaser of TPA claim contract services in the state, if not the country.

Recommendation #63– page 107

A study to determine if these high-volume doctors provide satisfactory care, earlier return-to-work, or reduced average wage loss would be instructive in designing medical access and treatment protocol.

Recommendation #64– page 107

Determine if there is a benefit to controlling certification, registration and training of doctors for disability opinions who treat workers' compensation patients.

Recommendation #66– page 108

Perform a study to determine what, if any, agency theory effect and costs and actions are taken by insolvent carriers as they near bankruptcy.

Recommendation #69– page 110

Summary and Recommendations



CHSWC study and facilitate discussions on methods to integrate occupational and non-occupational medical and disability programs.

Recommendation #71– page 111

Form a system-wide committee to develop strategies to deal with workers' compensation issues in the event of a terrorism act in California.

Recommendation #72– page 112

CHSWC study the rationale behind federalizing the workers' compensation system in order to understand the impacts of federalizing workers' compensation would have on California.

Recommendation #74– page 117

CHSWC, in conjunction with DWC, WCIRB and CDI, should coordinate and host a CEO summit for insurance carriers, employers, employees, self-insured employers, legislators and possibly reinsurance and surety companies.

Level C - Legislative Initiatives

Recommendation #18– page 60

Medical penalties should be payable partially to the state and partially to the provider.

Recommendation #56– page 97

Transfer Self-Insurance Plans from DIR Workers' Compensation to the Department of Insurance.

- One. DWC Claims Audit Analysis**
- Two. Zip Code Stratification Information**
- Three. Participants and Contributors**
- Four. Literature Review and Bibliography**

Appendix One

Analysis of Claims Handling Practices Using Division of Workers' Compensation Audit Unit Data

Study performed by Frank Neuhauser, University of California.

I. Introduction

A number of forces in the workers' compensation market over the past decade have put pressure on the claims handling practices of claims administrators. Open rating and the related pricing pressure have been the most commonly mentioned. However, there were also the numerous, possibly related, insolvencies among insurers, substantial shifts between the self-insured and insured markets, and the pressure to control rapidly rising indemnity and medical costs per claim. The first section of the report uses data collected by the Division of Workers' Compensation Audit Unit (AU) to evaluate whether the quality of claims handling has actually declined. We also examine whether entities that ultimately became insolvent (insurers) or bankrupt (self-insured employers) had poorer quality claims handling practices than the average claims administering location.

Several different measures of claims handling are:

- Frequency of violations found per file examined.
- Average amount of penalties assessed per file examined (a measure of the severity of the violations).
- Average amount of unpaid compensation per file examined.

We also explore in more detail some important issues like the timeliness of the first payment of temporary disability and the timeliness of subsequent disability payments.

This research is important because good claims handling practices are important to timely accurate delivery of benefits to injured workers who rely on these benefits to sustain their families. It also matters to employers who expect their workers to receive appropriate benefits and want to avoid the costly litigation that can arise when disputes over benefits lead to applications for adjudication.

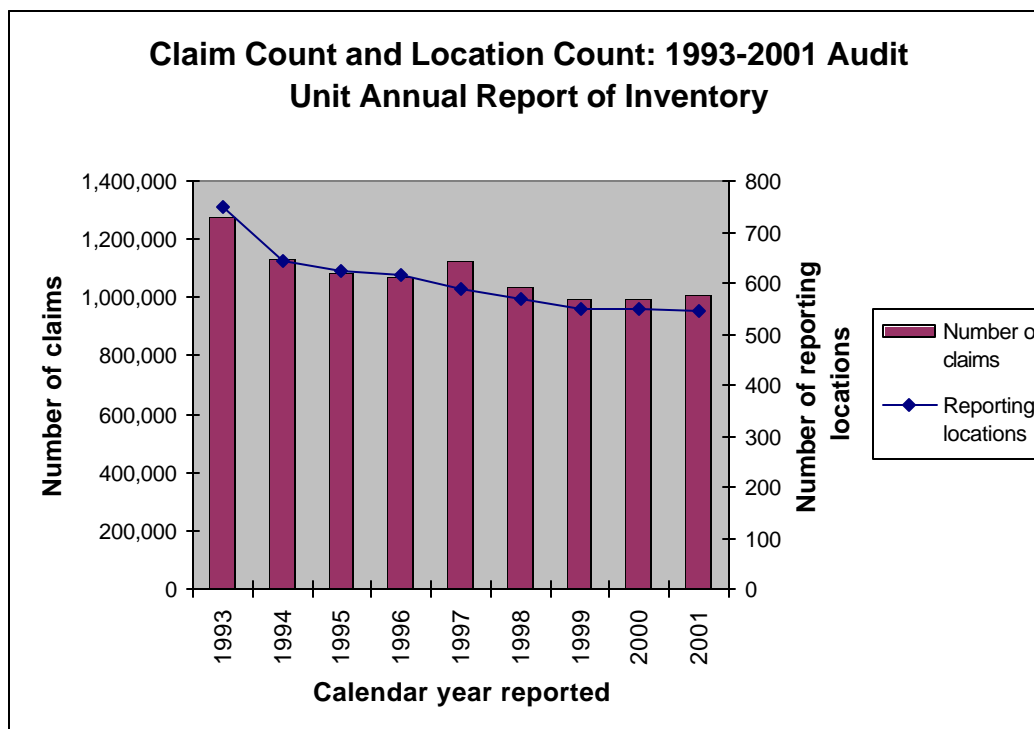
In the second section, we will look at some summary statistics about claims, claims handling locations and the number of audits. The third section examines specific types of violations. Next, we examine the question of the performance of insolvent carriers and bankrupt self-insured employers relative to the remaining solvent entities. Finally, in the fourth section, we discuss conclusions and implications for policy.

II. Summary Statistics on the System and Audits

Each year, the Audit Unit requests an inventory of all claims that were newly opened by each claims administering location handling California workers' compensation claims. The request covers the previous calendar year, unless the location can only report on a fiscal year basis. Technically, "new" claims include those that were reported for the first time to any administrator, as well as open claims that changed from one administrator to a different administrator. In practice, the Audit Unit thinks that the reporting of older claims that are switching locations is largely ignored. Consequently, these numbers represent a fairly good estimate of system-wide claims incidence.

The following chart shows the number of new claims handled and the number of claims administering locations.

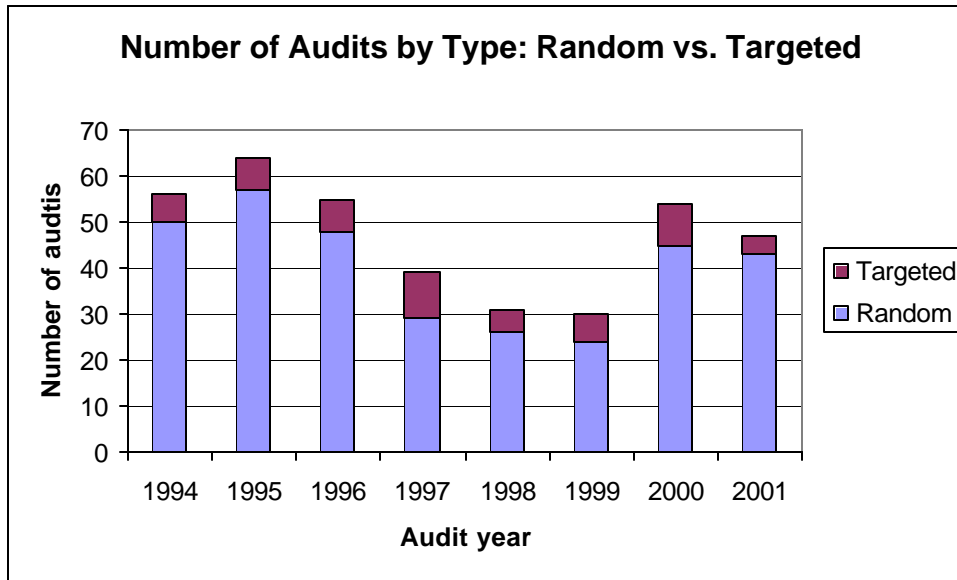
Chart A-1



During the 9-year period, calendar years 1993-2001, reported claims declined by 21.1%, while locations handling claims dropped by 27.2%. The consolidation of claims administrators seems to track well the decline in claim frequency and reflect less consolidation than observed in the insurance market.

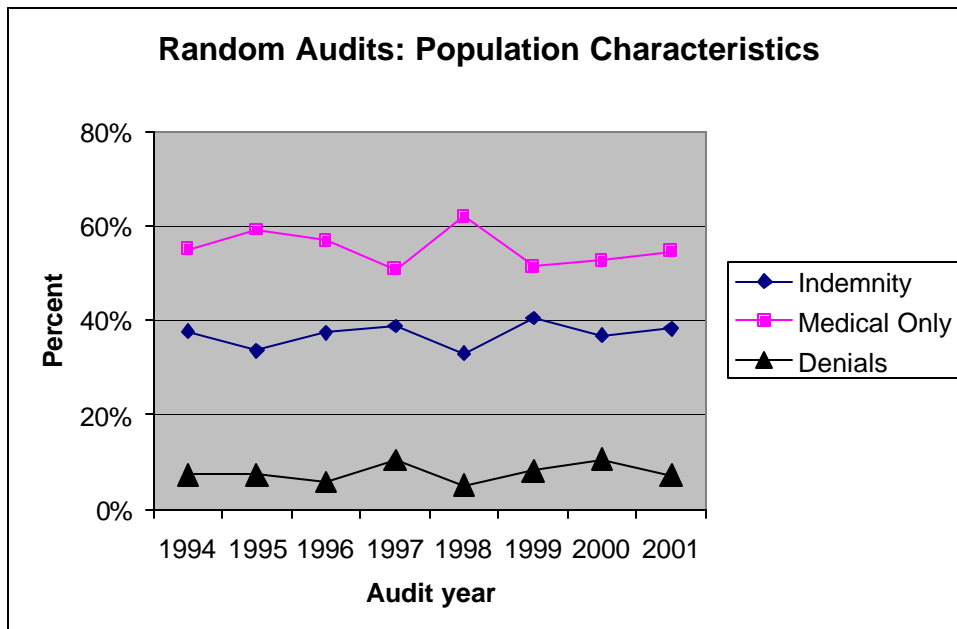
The Audit Unit conducts both random audits and audits that are targeted based on complaints and other criteria. Each year the distribution between random and targeted audits changes, and each year, the number of audits overall fluctuates. The number and type of audits done each year are shown below.

Chart A-2



The distribution of claim types (medical-only, indemnity, denial) has remained fairly constant over the period 1992-2000. This is not surprising, as we expect this distribution to change slowly unless there is a specific regulatory or statutory intervention.

Chart A-3



Notably, over this period, the percent of claims that resulted in denials has remained fairly constant. On average, the rate of denials has been about 6.8% of all claims filed. Also, the rate of denials was the same when examining both Random and Targeted (not shown) audits.

III. Trends in Claims Administration Performance

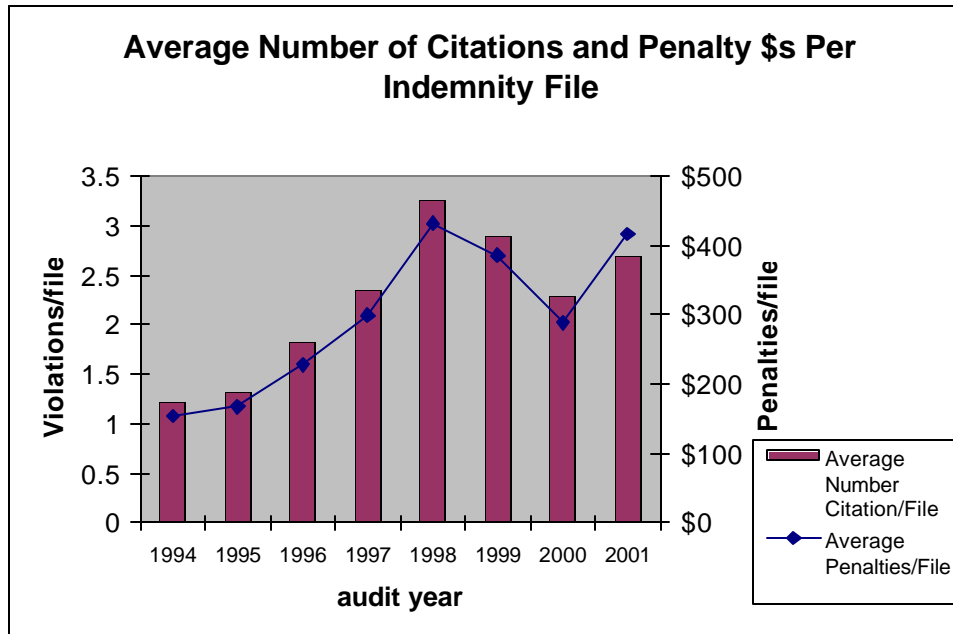
A) Frequency of violations and amount of penalties assessed

As with a number of other measures that we will review, there appears to have been a substantial deterioration in the quality of claims handling as measured by the number of violations found and the amount of penalties assessed. The chart below shows that the average number of citations and the average penalty dollars assessed per file have increased by between 200% and 300% since the period before open rating. The 1996 audit year would have picked up claims for dates of injury in 1994 and 1995 (the first year of open rating). The 1997 audit year is the first with nearly all claims from the post-open-rating period.

A number of reasons for this trend are possible. However, it does suggest the open-rating period has been characterized by poor claims handling practices. In a later section, we will discuss the evidence that the cause of this decline was the move to open rating.

Also note that the average number of violations and the average dollars track closely, suggesting that this period was not characterized by a shift to more serious violations (e.g., unsupported denials instead of late first payment of temporary disability), just several times more mistakes on the average claim and/or a higher portion of claims with mistakes.

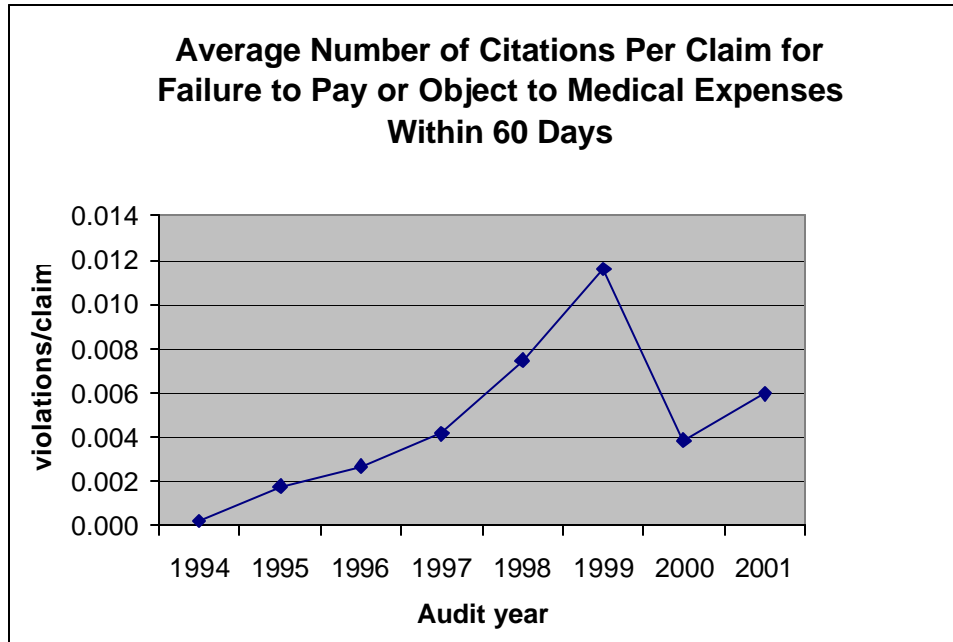
Chart A-4



B) Frequency with which specific types of violations were found by the Audit Unit

In examining specific types of violations, we began with one that is often raised by medical providers, late payment of medical bills. By statute, claims administrators are required to pay or object to medical bills within 60 days. While we do find that the trend over time is towards more violations of this statutory requirement, violations are actually quite infrequent. Even in the worst year, there was an average of only one violation assessed per 100 files, despite the fact that there may be many medical bills for a single file.

Chart A-5



It should be noted that we cannot tell from these data how often claims administrators did not pay within 60 days because they met the statutory requirement by objecting to the bill instead. In addition, the Audit Unit does not assess violations for late payment of medical bills if it believes the doctor was selected by the employer because there may be contracting language allowing different payment periods. However, it appears that timely payment of medical bills is not the major problem that anecdote has suggested.

For this particular analysis, we summed violations in the category and divided by the total number of files examined. For subsequent analyses, we will usually limit the denominator to indemnity files because most violations, such as late first payment of TD, are only appropriate for indemnity files.

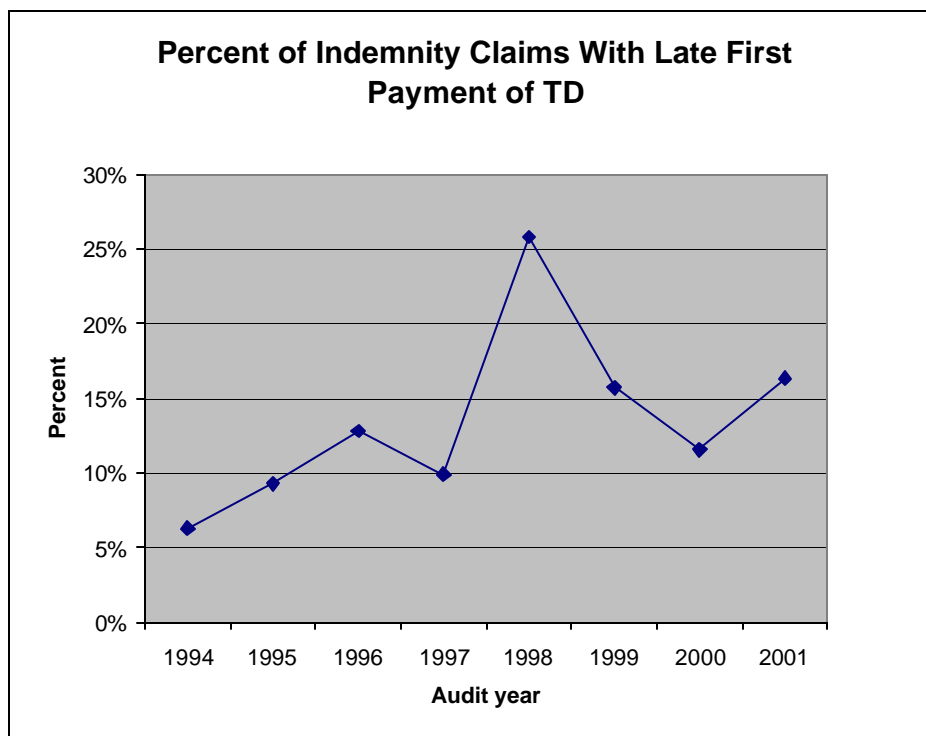
It should also be noted that because there are a relatively small number of audits, especially in the 1997-99 period, we sometimes get large jumps or declines in the data like we observe for 1999 in the above chart, when a particularly large claims administrator has a particularly bad audit for a particular violation type. It is better to consider the trend during the whole time period rather than focus on any single year.

C) TD

A commonly used measure of the quality of claims handling is the timeliness of first payment of temporary disability (TD). Statute requires that first payment be made within 14 days.

While not as steep as the trend we observe in other measures, it does appear that over the time period under study, there was a general decline in claims administrators' performance on this measure. Late first payment ranges from 5-10% early in the period before open rating, to around 15% late in the period. Actual rates are somewhat higher because we do not know the number of indemnity claims that did not have any TD payments (PD only, death, etc.) nor how often an initial objection allowed the claims administrator more than 14 days to make an initial payment.

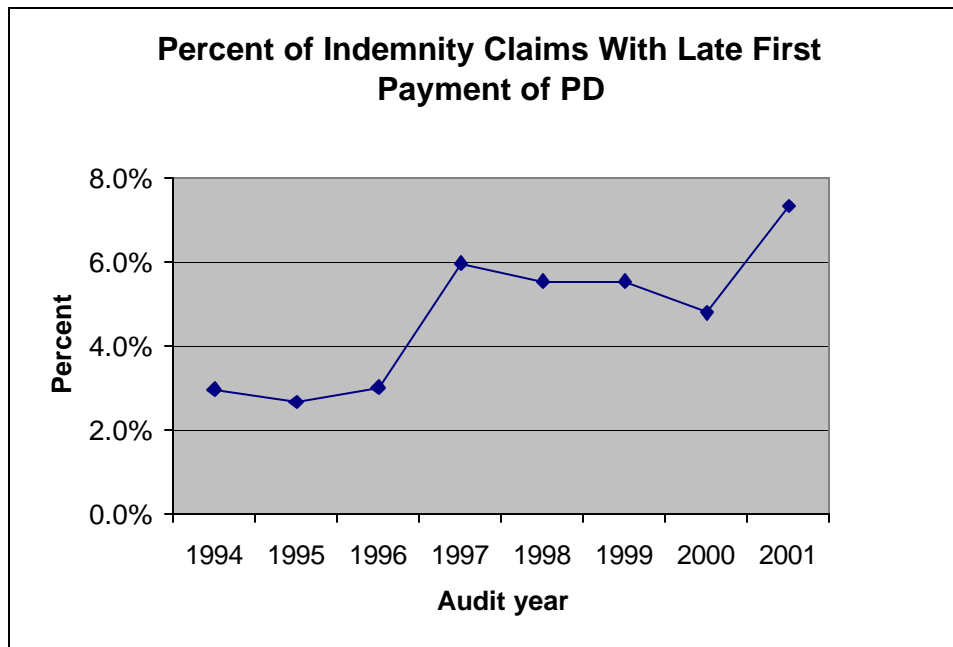
Chart A-6



D) Late first payment of permanent disability (PD)

Next, we examine late first payment of permanent disability (PD). We use indemnity claims as the denominator. The reader should be aware that only about 40% of indemnity claims receive permanent disability payments; consequently, the percent of claims that qualify for PD and receive a late payment is actually about 2.5 times higher than the rate shown here. That suggests that over the period observed, the rate of late payment of the first PD has risen from 6-7% to something closer to 15-18%.

Chart A-7

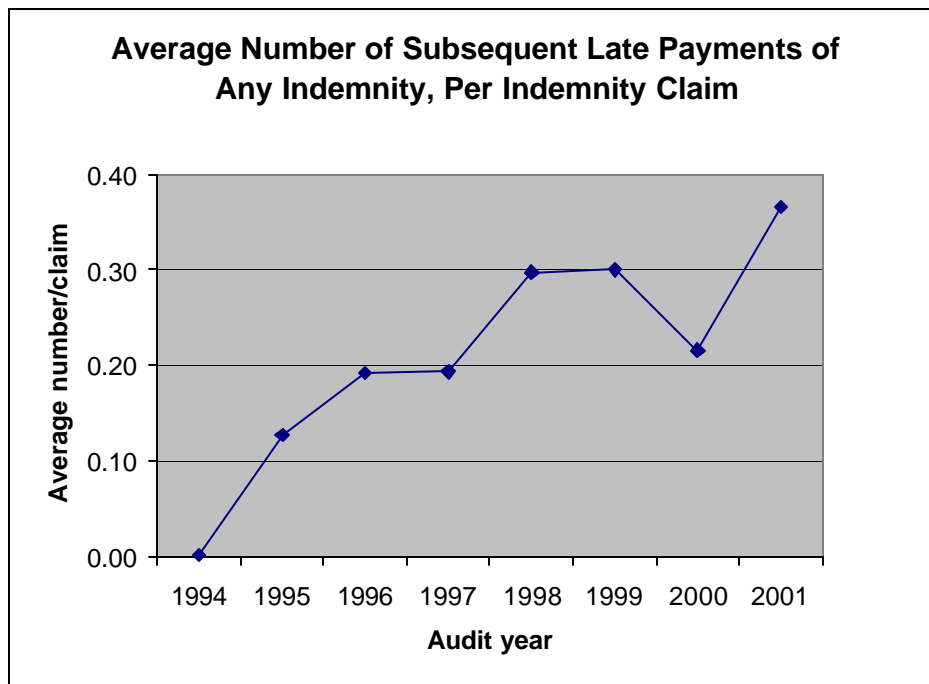


Again we see that for an important measure of claims performance, there has been a substantial decline in claim handling quality over this nine-year period.

E) Late subsequent payments of indemnity

In addition to 1st payment of TD, PD, and Vocational Rehabilitation (not shown), there are usually subsequent payments of one or more of these types of indemnity. The Audit Unit issues citations for these violations, and of course, can issue multiple citations per claim. Here we show the average number of citations per indemnity claim file for late payment of a subsequent (not first) payment of indemnity. Again, we see a substantial trend towards increasing violations of timely payment of indemnity.

Chart A-8

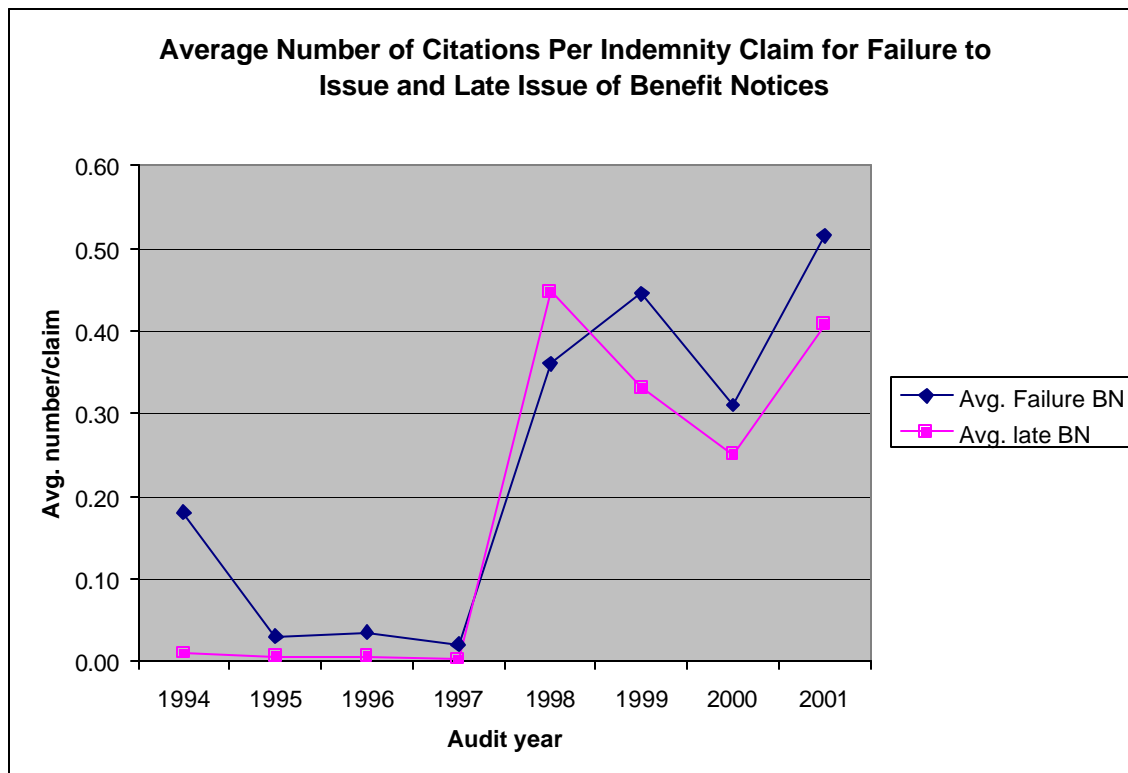


It should be noted that the low numbers of citations for the 1994 audit year (and possibly 1995) may be a result of the phasing in of a new procedure; we are checking with the Audit Unit on this issue.

F) Benefit Notices

Benefit notices are issued at important junctures in the claim process where it is necessary to inform workers about changes in their benefit payments, the eligibility for additional benefits, and medical legal processes. The following chart shows the average number of citations issued for failure to issue benefit notices and for late issuance of benefit notices. More than one citation can be issued on a file, because there are often numerous notices required by statute.

Chart A-9



Again, we find evidence that claims handling practices have declined in quality.

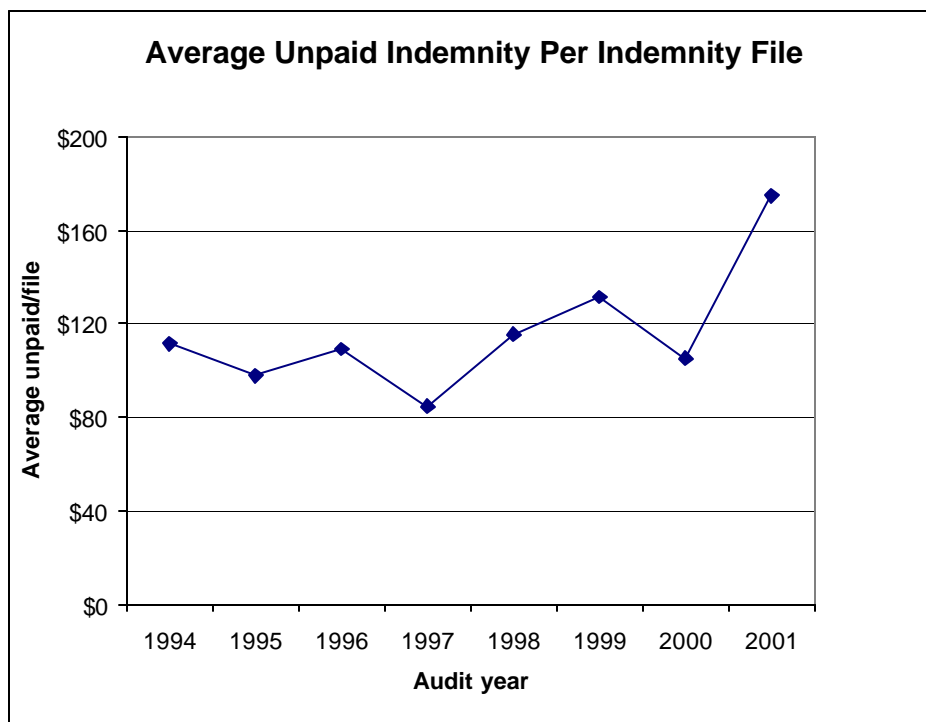
The differences observed between audit year 1997 and subsequent years may be the result of changes in the statutory or regulatory environment. We are checking with the Audit Unit about this issue.

G) Unpaid compensation

One of the most important violations for which the AU audits is unpaid compensation. A citation is issued when a worker receives less than he/she was entitled to by law. The claims administrator is also required to pay the worker the compensation and any penalties for late payment.

Here the trend towards poorer claims handling is not as clear as it was for the violation reviewed earlier. The jump in audit year 2001 is not sufficient by itself to imply deterioration in claims handling. Remember, that we previously observed one-year jumps and declines.

Chart A-10

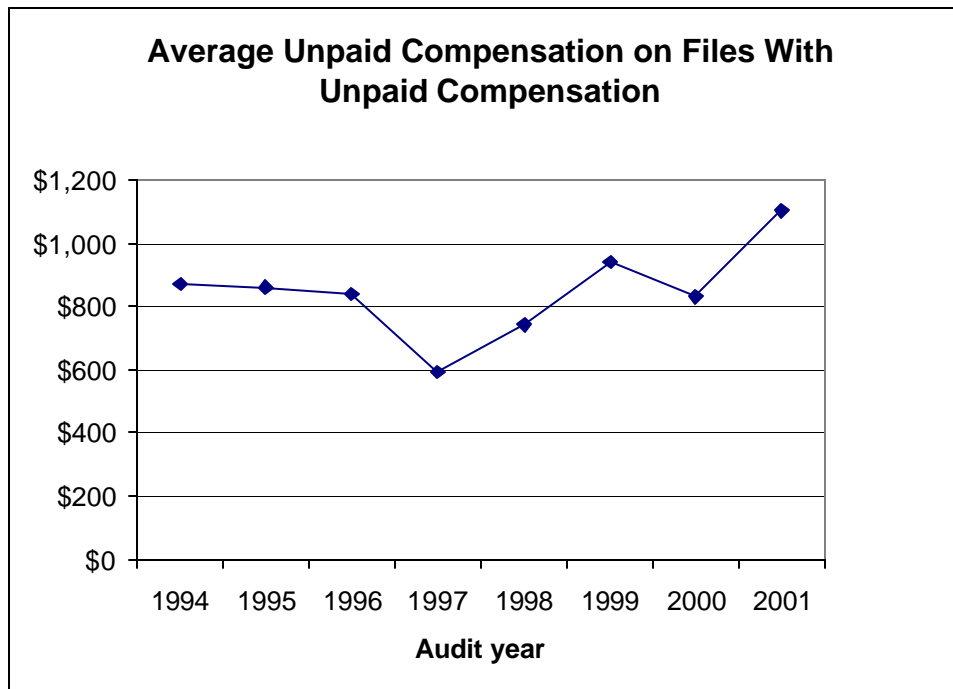


In addition, we would expect some trend up in the average amounts of unpaid compensation even if claims handling practices remained steady, because the average compensation paid on claims increased over this period substantially, particularly after the legislative increases of 1994-1996, which would affect audit years beginning in 1996.

One possible explanation for the consistency in the performance on this measure relative to the trends we saw on the previous measures is that substantial penalties are applied outside of the audit process for underpayment and late payment of compensation, both through the self-imposed 10% penalty and the more severe 5814 penalty process. Claims administrators have always had important incentives to pay compensation correctly.

The following chart emphasizes just how important the issue of unpaid compensation can be to the individual worker. In the chart above, we averaged the unpaid compensation across all indemnity files examined, whether or not the file contained any unpaid compensation. Below we look at the average amount of unpaid compensation found, when any unpaid compensation was found. When a worker is underpaid, it is by an average of around \$800. This can be an important amount of money to a worker who is struggling with a disability.

Chart A-11



The Audit Unit only examines claims opened at a location in the previous two calendar years. Consequently, claims reviewed are an average of 18 months post injury. With approximately 350,000 indemnity claims a year and an average underpayment of \$115 on each claim, an estimated \$40,000,000 in compensation is underpaid to workers each year, just during the first 18 months the claims are open. A substantial amount of indemnity is paid after the first 18 months. This suggests that \$40,000,000 is a conservative estimate of the annual underpayment of compensation to injured workers.

H) Comparing Solvent and Insolvent Insurers/Self-Insured Employers

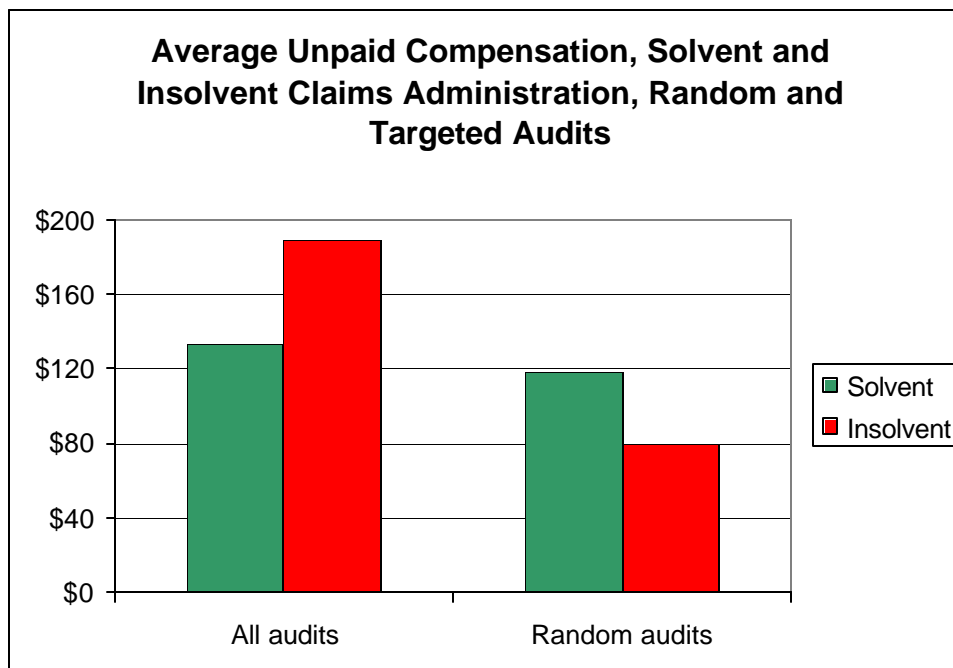
An interesting question, beyond changes in the quality of claims handling over time, is whether or not insolvent insurers handled their claims less well than insurers and self-insured employers that remained solvent. This could be either a cause of insolvency, an effect of insolvency, or both. Bad business practice may reflect itself in poor claims handling, leading to more disputes, more penalties, higher costs, and ultimately, a higher chance of insolvency. Another alternative is that weak financials can lead to cuts in claims handling staff and budget or switching to lower-budget TPAs.

The results of poor claim handling practices are felt by both employers and workers. Employers face the potentially higher cost of poor administration. Employees risk loss of benefits and longer delays until disputes are resolved and benefits paid. If insolvencies have an important effect on claims handling, then statutory and regulatory action to reduce the risk of insolvencies becomes even more of a concern.

We identified audit locations as “insolvent” based on whether the insurer or self-insured/self-administered employer ultimately went insolvent or bankrupt. If it was a TPA with a sole client that went insolvent or bankrupt, that location was also identified as “insolvent.” Of the 376 audits for which we had data between 1994 and 2001, 345 (91.8%) were classified as solvent, 28 (7.5%) as insolvent (by 2002), and 4 had inconclusive data.

The following chart compares the two groups of carriers on the important dimension of unpaid compensation. The comparison is on the average amount of unpaid compensation on indemnity files audited. When all audits are included, random and targeted, insolvent carriers averaged \$56 (42%) more unpaid compensation per indemnity case.

Chart A-12



However, audits of insolvent locations (26.7%) were twice as likely to be targeted audits as audits of solvent locations (13.3%). When we use just the random audits, the insolvent locations performed slightly better (the difference is not statistically significant). The performance of insolvent locations, on the dimension of paying compensation, appears at least as good as that of those administrators that remained solvent though this whole period. That still leaves open the question of why the insolvent locations were more likely to be targeted. We cannot answer that question.

We also evaluated the quality of claims handling for these two groups using the measures of the average number of violations found per indemnity file and the average amount of penalty dollars assessed per indemnity file. On both of these measures the insolvent locations performed more poorly when all audits (targeted and random) were used, but the two groups were identical when only the random audits were used.

Chart A-13

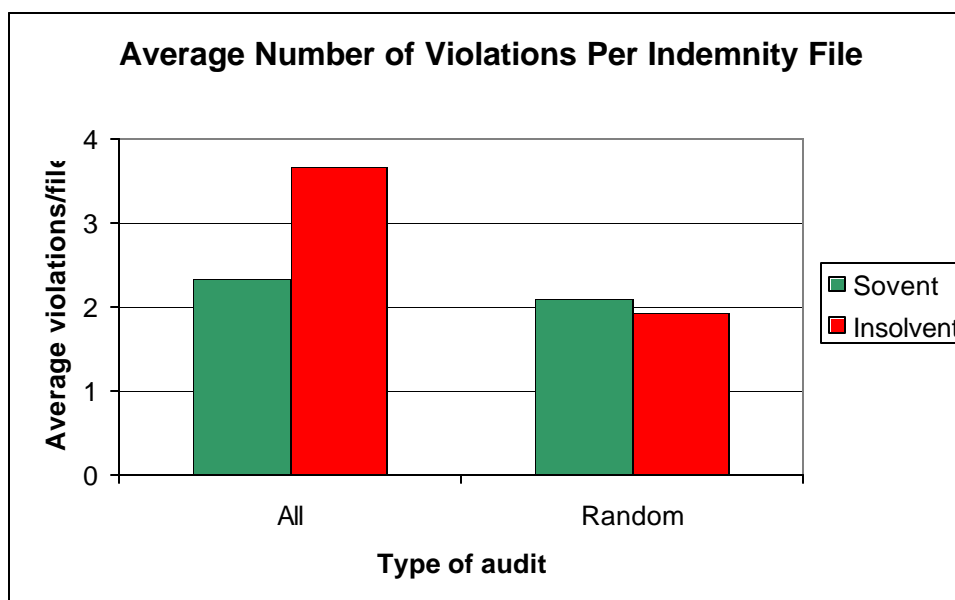
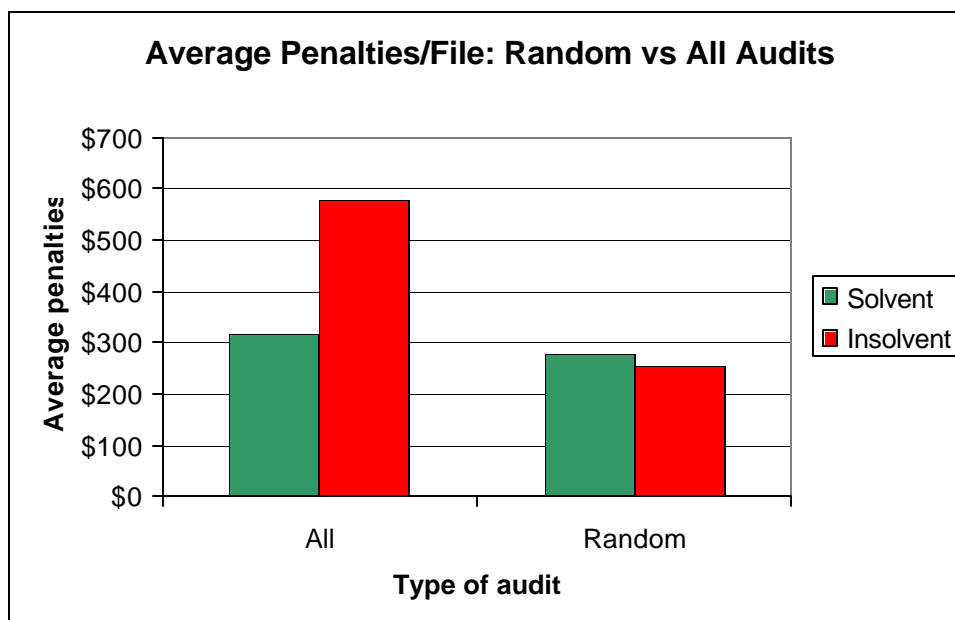


Chart A-14



We see no evidence that the financial weakness of the insurer or self-insured employer led to poorer claims handling that would have had a negative impact on workers or employers.

The reader should consider that this analysis might underestimate the differences between solvent and insolvent entities. As we saw in the previous section, violations,

penalties and, possibly, average unpaid compensation have been increasing over time, but insolvent entities will be less and less likely to be audited over time as they exit the market. This could lead to a downward bias in estimates of violations for insolvent entities.

Also, there is evidence that once an entity becomes insolvent or a self-insured employer enters bankruptcy, there can be substantial delays in the next series of payments to workers while a transition is arranged by the CIGA or SIP. We are unable to obtain data to measure this effect.

Is the Decline Caused by Open Rating?

In a system with many forces affecting performance, it is difficult to attribute the cause of an observed change to any particular source. However, there is evidence that the deterioration in the quality of claims handling was related to the move to open rating.

We used several regression approaches to analyze the different types of locations and time periods. The results are all consistent with what we would expect if open rating is driving the trends we observe.

First, we split the time period into the period “before” open rating, “during” the year where claims were $\frac{1}{2}$ and $\frac{1}{2}$ (1996), and “after” open rating. When analyzing the average number of penalties/indemnity file and the average penalty dollars/indemnity file, we got statistically significant and important coefficients on the “during” and “after” variables suggesting a relationship between the periods and the quality of claims handling.

The size of the coefficient on “during” was about half of that for “after,” consistent with the “during” period being a transition with half the claims from a year before open rating. Also, the “year” variable that would identify a trend over the entire time period, independent of the discontinuities in the levels, did not have a significant coefficient and the size of the coefficient was small.

Finally, we ran the same analyses separately for locations that were identified as self-insured/self-administered employers, Third-Party Administrators (TPA), and insurers. We expect that the effect of open rating will be very limited on self-insured/self-administered employers and greatest on insured locations. At the same time, most other changes in the workers’ compensation environment would affect self-insured employers and insurers similarly. TPAs, which handle both self-insured and insured claims and are insulated somewhat from pricing issues, would be expected to fall somewhere in between self-insured employers and insurers in terms of changes in claims performance if those changes were driven by open rating.

This final set of analyses is consistent with our expectations. There was no statistically significant changes in self-insured/self-administered employer performance related to the “during” and “after” periods or the trend line based on the year of audit. At the same time, there were significant effects associated with both TPAs and insurers for both the

“during” and “after” periods. The coefficients for insurers were overall larger and more statistically significant.

This gives support to the contention that open rating has led to the decline in claims handling performance, possibly through the financial pressure felt by operations in a market with aggressive pricing. However, it should be noted that the period of observation, especially before open rating is short, making it more difficult to consider this analysis conclusive.

Also, there were a number of other changes enacted legislatively at the same time. These could also have played a role. The most convincing evidence is that self-insured employers’ results did not apparently deteriorate to the same extent as insurers’ performance. Here the most important caveat is that we have a smaller number of audits on self-insured employers so it is difficult to get convincing statistical results for this group.

Methodology

Data on each audit was obtained from the DWC Audit Unit. Some of the data were in electronic format and some were hard copy. CHSWC staff did the initial data entry and formatting to set up the analysis file.

The audited entities were then matched to lists of insolvent insurers and estates under the supervision of the DIR Self -insured Plans to identify insolvent insurers and bankrupt employers.

The audits were identified as random or targeted based on data supplied by the Audit Unit.

Finally, the data were weighted to reflect the size of the audited location (number of files opened in the years subject to audit relative to the number of files in the sample audited). When using the random audits, this weighting allows us to make inferences about the whole population of claims.

Discussions and Conclusions

Over the period under study, the quality of claims handling declined substantially. Both the number of violations and the penalties assigned increased substantially. This was true despite a declining total caseload.

The deterioration in claims handling, however, was not necessarily reflected in the level of unpaid compensation. Despite increases in the average indemnity paid per case, the average amount of unpaid compensation on indemnity files does not have a clear trend. Looking at differences between solvent and insolvent entities, there is no indication that claims administration by entities that became insolvent during this period had worse

claims handling practices prior to being taken over by CIGA or SIP. While on average, insolvent entities had more frequent violations and more penalties assessed, the difference is entirely explained by the greater portion of insolvent locations that were targeted for audits. The results for random audits were virtually indistinguishable between solvent and insolvent locations.

This does leave open the question of why the locations that eventually became insolvent were more likely to be singled out for targeted audits. The number of targeted audits at locations that eventually were insolvent is small, and it is difficult to reach conclusions.

There is no absolute measure of “good” claims handling, and consequently, no way to judge whether current claims practices are “adequate.” However the continued decline in claims practices suggests that the California system is going in the wrong direction, depriving workers of timely compensation and information and potentially burdening employers with higher costs through increased litigation and additional labor-management problems.

We cannot say definitively that this decline in quality is a result of open rating and the price competition that followed. However, the evidence about the timing of the changes in practice and the limited changes seen on self-insured/self-administered employers is strong evidence suggesting a relationship. It is not clear that some form of re-regulation of the insurance market will lead to better claims practices. It might be appropriate to consider standards for claims handling in combination with any partial reregulation.

One important step has already been made to improve claims handling. AB-749 adopted nearly all of the recommendations made by CHSWC for improving the audit process. These changes eliminate much of the burden of the audit on locations with good practices and increase substantially the penalties on the worse performing locations. This will increase substantially the incentives for improving claims handling and the visibility of both the best and worst performers.

Appendix Two

Zip Code Stratification for Regional Analysis

The first three digits of
the ZIP Code

North
Coast 955, 954

North
Inland 956, 957, 959, 960, 961

Central
Coast 939, 940, 941, 943-44, 946-
950

Central
Inland 932-33, 935-38, 942, 945,
951-53, 958

South
Coast 900-921, 926-28, 930-31

South
Inland 922-925

Appendix Three

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The following people have graciously contributed their time, insight, opinions and observations to the report. The validity and usefulness of this report are in large part due to their willingness to share their expertise on the California system.

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Appendix Four

Literature Review and Bibliography

Literature Review

AB 749—Is Everybody Ready for Unintended Consequences? (2002). *Workers' Comp Executive*, 12(19), 1,4.

David Bellusci, chief actuary for the Workers' Compensation Insurance Rating Bureau, says, "...the economic decision of whether a worker files a claim has changed. Once benefits go up close to what they're making, you've changed the equation." He also predicts that the employers that have "a lot of part-time minimum wage workers" will feel the effects of increasing frequency.

Beisiegel, Cynthia. (2002). California Workers' Comp Hanging By a Thread. [Electronic version] *Insurance Journal*. Retrieved May 31, 2002, from Insurance Journal Web site:

<http://www.insurancejournal.com/html/ijweb/publications/IJWest/w052702/hangingby.htm>.

The CWCi believes that AB 749, increasing medical costs, reinsurance issues, rising premium costs, the subjectivity of the permanent disability rating system, and continued strain on the California Insurance Guaranty Association are the issues causing the current turmoil in the market. Diminishing competition among carriers also causes worry. To add to this was the lowering of the SCIF rating by A.M. Best and then the Fund's withdrawal of the rating. It is critical for SCIF to remain healthy to provide 'shock absorber' protection for employers. It is also believed that the most important role California faces is that of instilling confidence back in to the workers' compensation market. They hope to do this through attracting capital from companies who have economic, line, and geographic diversity. California also faces the unique vulnerability to earthquakes that could add pressure to the California system, but also to reinsurers worldwide.

California Bill Information. (2002, September 9). Retrieved January 17, 2003, from the California State Law, Code, and Regulation Links Web site: http://www.leginfo.ca.gov/pub/01-02/bill/asm/ab_2001-2050/ab_2007_bill_20020909_chaptered.html.

AB 2007 establishes the provision the premium charged to member insurers at a limit of 2% effective January 1, 2003, until December 31,

2007, thereafter being 1%. The premium charged shall not be more than 2% of the net direct written premium.

California Commissioner Orders SCIF to Reduce Broker Commissions. (2003, March 4). Retrieved March 5, 2003, from Insurance Journal Web site:
<http://www.insurancejournal.com/news/newswire/west/2003/03/0426744.htm>

California Commissioner John Garamendi proposed a seven-point plan to right the current situation at SCIF:

1. State Fund will retain a management consultant.
2. Dramatically reduce new business.
3. Effective July 1, State Fund will implement a further rate increase on new and renewal policies.
4. State Fund will reduce broker commission rates. A broker who consistently writes unprofitable book of business will lose certification.
5. State Fund will explore reinsurance arrangements to reduce the strain on its surplus.
6. State Fund will strengthen its underwriting practices.
7. State Fund will review all accounts and then implement appropriate surcharges.

Capacity of the National Network of State Guaranty Associations to Protect Consumers of Nationally Chartered Insurance Companies. (2002). *National Conference of Insurance Guaranty Funds (NCIGF)*. Retrieved January 15, 2003, from NCIGF Web site: www.ncigf.com.

NCIGF provides national assistance to guaranty funds, assists in coordinating activities and communications between liquidators of insolvent insurance companies, and guaranty funds, along with other interested parties. The large number of insolvencies has placed a strain on a few states' assessment capacities in one or more of their assessment accounts.

Ceniceros, Roberto. (2000) California Insurers' Comp Losses Soar. *Business Insurance*, 34 (3), 3.

The severity of losses has continued to grow. Currently, many carriers are trying to make up for past sins of abnormally low rates. Insurers are seeking more customer participation in controlling their loss experience. Even accounts with good loss history are experiencing increasing rates.

Ceniceros, Roberto. (2002). Comp Guaranty Fund Facing Shortfall. *Business Insurance*, 36 (31), 3-6. Retrieved January 10, 2003, from ABI/Inform Proquest database.

California's Self Insurers' Security Fund assessed employers the maximum 2% of benefits paid annually to help recover from the projected

50 million dollar deficit that the fund is facing.. This deficit is due to taking over claims payments for two self-insured employers, with one employer being estimated with \$32 million in outstanding claims. It is being proposed that the Security Fund would in the future be able to back members' security obligations by starting a pool rather than employers having to buy a bond for credit.

Commission Report, Volume I, Executive Summary Report (Dennis J. Aigner, PhD., Chairman). (1992). Workers' Compensation Rate Study Commission: State of California.

Experience in other states which moved to a more competitive market indicate that employer costs fall when regulatory constraints are eased; cutthroat competition resulting in widespread insurer insolvency and lack of availability have not occurred. This is a very detailed study that contains a mass amount of data to support this finding, but as experience has told us in California, the exact opposite happened. The exact opposite occurred due, in part, to the incorrect underlying assumption that all parties involved will act in the best interest of the social good.

CWCI Study Examines Chiropractic Utilization and Costs in Calif. WC. (2003, March 26). Insurance Journal. Retrieved March 26, 2003, from the Insurance Journal Web site:
<http://www.insurancejournal.com/news/newswire/national/2003/03/26/27387.htm>

The average cost and overall cost of chiropractic care in California workers' compensation has been caused by an increase with higher levels of chiropractic services per claim. Workers' compensation payments to chiropractors climbed from \$77 million in 1996 to \$195 million in 2001. Even though the number of work injuries and proportion of workers' comp claims involving chiropractic treatment has declined, chiropractic costs more than doubled. The number of chiropractors to injured workers has increased by 1/3 between 1995 and 2000, which is referred to as physician-induced demand.

Debber, Dale. (2003, April 9). State Fund Practices Vindicated in A & J Liquor Case. *Workers' Comp Executive*, 13(7), 1-2.

State Compensation Insurance Fund had an unmitigated victory on Monday, April 7, 2003, when it was ruled that the plaintiffs failed to prove any of their causes of action. The decision would make a good primer on California workers' compensation history. It reviews the environment for the years in question and shows clearly how reserving practices changed during the period. It also show unique depth, for a layperson, in how claims reserving works and how reserves need to be adjusted in a changing environment. SCIF has traditionally been more conservative,

and in hindsight, more accurate in its reserving practices than competing carriers in California.

Dykhouse, David J. (1993). *Final Report on The State of Competition in the Workers' Compensation Insurance Market*. State of Michigan: Department of Commerce, Insurance Bureau.

Overall evidence indicates that there is a reasonable degree of competition in the Michigan workers' compensation insurance market. In 1982, a competitive regulatory environment was established with the following conditions:

1. Allowing insurers to file rates and use them without first receiving approval from the insurance commissioner.
2. Prohibiting cartel rate filings and abolishing rating bureaus.
3. Allowing insurers to share only loss cost information needed to make pricing decisions.
4. Prohibiting insurers from requiring the purchase of other types of insurance as a condition for obtaining workers' compensation insurance.

According to economic theory, an industry is perfectly competitive only when the number of firms selling a homogeneous commodity is so large and each individual firm's share of the market is so small, that no individual firm is able to affect the price of the commodity. Apparently, no one insurer is large enough to control the Michigan workers' compensation insurance market independently, the State Fund controlled 15.31% at the time, and there are numerous insurers overall. There is still the question of whether the industry is concentrated enough among the leading companies to enable them to use price collusion or otherwise limit their competition.

Employers Working the Legislature on Workers' Comp. (2003.) *Workers' Comp Executive*, 13(3), 5, 10.

The Assembly Insurance Committee's chief priorities are to ensure that the Division of Workers' Compensation is fully funded to keep the system functioning and to implement reforms contained in last year's benefit bill. Also, companies are leaving the state to avoid what they consider a hostile business environment, of which workers' compensation is a key component. The lawmakers want to reform workers' compensation medical care by proposing that every doctor who treats or evaluates injured workers must be certified by the state to practice occupational medicine.

Green, Meg. (2003, April 9). Liberty Mutual: Workers' Comp Climate Friendly Despite Medical Inflation Increase. Retrieved April 10, 2003, from A.M. Best Web site: <http://www3.ambest.com/Frames/FrameServer.asp?Site=news&Tab=1&altsrc=18&RefNum=56961>.

All sizes of companies are in near crisis with their workers' compensation coverage, as stated by Richard G.M. Marko, senior vice president of nation market administration for Liberty Mutual. Marko also believes that chronic pain treatments and chiropractic care are driving the increase in medical claims cost.

Commissioner Harry W. Low wants SCIF to return to being "the insurer of last resort." SCIF has agreed to comply to the stated risk-based capital level, even though due to a loophole in California law, the monocline, California-only, government-run fund is not required to follow risk-based capital guidelines. The fund has paid out about \$1.32 in claims and expenses for every \$1 in revenue it received for the past five years. Most workers' compensation insurers were able to make up money lost on unprofitable business through investment income, but then the capital markets faltered and so did their balance sheets. The fund covers 260,000 policyholders--- not many more than the 248,600 policyholders it had in 1995 when open rating was started.

Hanavan, Brett. (2002). MGA Sees Opportunity in Troubled California Comp Market. *Rough Notes*, 145(6), 44 -45. Retrieved January 10, 2003, from ABI/Inform Proquest database.

Bill Trzos views the current situation in California "as an opportune time if you can select risk and underwrite objectively.' Their expectation for underwriting profits is approximately three years; writing only controlled business and making underwriting very selective. Trzos and Boyd's priority is to protect the investment of backing companies. The problem for most insurers has been a dramatic increase in severity, with an average cost of an indemnity claim hitting \$43,300 in 2001. Cypress Point also plans to target homogeneous groups, programs, and associations.

Hartwig, Dr. Robert P. (2002). Special Report: Earlybird Forecast 2003. *Insurance Information Institute*. Retrieved January 17, 2003, from Insurance Information Institute Web site: <http://www.iii.org/media/industry/financials/forecast2003>.

According to the Risk and Insurance Management Society, the cost of risk for businesses relative to revenues fell by 43 percent between 1992 and 2000. Even with the increases of the past two years, businesses are still paying an estimated 13 percent less to manage risk than they were a

decade ago. The actual decline is greater still because terms of coverage were substantially broadened during the 1990's.

Insolvencies/Guaranty Funds. (2002, August). *Insurance Information Institute*. Retrieved January 16, 2003, from the Insurance Information Institute Web site: <http://www.iii.org/media/hottopics/insurance/insolvencies>.

Insurance company insolvencies are rising, according to rating agency A.M. Best. Inadequate reserves, under pricing and too rapid growth are the major reasons for the increases. NAIC has developed a series of tests, such as the Insurance Regulatory Information System (IRIS), which facilitates the early identification of companies in trouble. All insurers are required to file annual financial statements with regulators in all states in which they are licensed to do business. A 1990 report conducted by Rep. John Dingell (D-MI), entitled "Failed Promises: Insurance Company Insolvencies," found "disturbing" parallels between the mismanagement and fraudulent activity that led to the four insurer insolvencies and the factor that precipitated the savings and loan crisis. Specifically, it attributed the insurance company failures to rapid expansion, unsupervised delegation of authority, extensive and complex reinsurance arrangements, underpricing, reserve problems, false reports, reckless management, incompetence, fraud, greed, and self-dealing.

Johnson, Kelly. (2003, May 2). Rising Costs Fuel New Self-Insurance Options. Retrieved May 7, 2003, from The Sacramento Business Journal Web site: <http://sacramento.bizjournals.com/sacramento/stories/2003/05/05/story4.html>.

Many self-insurance pools are forming to handle workers' compensation in the state of California to escape increasing costs. The drawback of pools is that members must share their financials with others in the pool, even if they are a competitors. Also, if the industry as a whole is hurting, the self-insured pools formed could be hurting a great deal. The actuarial, claims management, banking, accounting, brokerage and other services are all subcontracted out. Members pay a premium based on their payroll or number of employees. Those contributions fund expenses and pay any claims. The members get back any surplus.

Johnson, Kelly. (2002). Workers' Comp Misery Spreads. [Electronic version]. *Sacramento Business Journal*. Retrieved October 2, 2002, from Sacramento Business Journal Web site: <http://sacramento.bizjournals.com/sacramento/stories/2002/09/30/story1.html>.

Higher benefits will be applied to claims starting January 1, 2003, due to Assembly Bill 749. By the time it is fully implemented in 2006, it will increase employers' costs by 22.8%, including a 5.9% net in 2003 alone. The bureau estimates the total cost of AB 749 at \$3.2 billion. Director of

the Californian Coalition on Workers' Compensation, Lori Kammerer, hopes that regulatory and administrative changes to the workers' compensation system can save money to counter the increasing benefits paid out.

Johnson, Kelly. (2002). Workers' Comp Tab: \$15B now, \$20B Soon. [Electronic version]. *Sacramento Business Journal*. Retrieved October 30, 2002 from Sacramento Business Journal Web site:
<http://sacramento.bizjournals.com/sacramento/stories/2002/10/28/story6.html>.

This article points to higher workers' compensation rates due to the expanding economy in the state, increased benefits for injured workers and higher wage trends. It is also thought that the current trend of declining claim frequency will end over the next year or so because injured workers will have more economic incentive to file a claim or use the workers' compensation system.

Mingo, Stefani. (2002, March 25). California's Workers' Comp is it Recovering? *Insurance Journal*. Retrieved January 12, 2003 from Insurance Journal Web site:
<http://www.insurancejournal.com/magazines/west/2002/03/25/features/18859.htm>

According to SCIF's Christensen, the statistics reveal that the industry is headed right back to where it was before open rating. "Prices are going to soar, employers are going to go nuts, and the Legislature will go crazy," he said.

Outgoing State Fund Head Highlights Compensation Crisis. (2002). *Insurance Day, October 1, 2002 (Special report)*. Retrieved January 10, 2003, from LexisNexis database.

SCIF's loss reserves have been found reasonable at year-end for the past three years by PricewaterhouseCoopers, Milliman US, and the California Department of Insurance's (CDI) consulting actuary. SCIF reserves for future losses and loss adjustment expense stand at \$7.6 billion, and the reserves are backed by \$8.7 billion in bonds on deposit with California's treasurer. Commissioner Low directed SCIF to "strongly consider":

- Increased rates.
- Eliminating credits.
- Discounts.
- Dividends.
- Eliminating or reducing commissions.
- Practicing an insurer-of-last-resort philosophy by only accepting accounts that are unable to procure WC coverage elsewhere.

These were also later recommended by Commissioner Garamanedi, and some have been implemented by SCIF.

Payne, Melanie. (2002). Business Owners Fear Rising Workers' Compensation Insurance Rates. *The Sacramento Bee*. Retrieved October 15, 2002, from LexisNexis database.

Rates have risen 77 percent in over the past three years and are expected to continue to rise again to pay for benefit increases passed into law in 2002. Employees file just under one million claims annually, 20 percent of which are involved in litigation. This article cites system cost, mismanagement and fraud as leading reasons for the toppling of the \$11 billion dollar workers' compensation system in California. The costs of claims are also increasing, which further contributes to an extremely high industry loss ratio. It might take total collapse to spur reform of this workers' compensation system gone bad.

Privacy, Comp Big Issues in West. (2003). *Insurance Chronicle*, 14 (3), 1. Retrieved January 10, 2003, from LexisNexis database.

Among the ways proposed to cut spending for states facing a budget crunch in the West, it has been proposed that state workers' compensation guaranty funds be privatized. Privatization is something pressed for by business groups in most states have pushed for, but it has not won much support from the insurance industry or from government officials hesitant to change the system. Two primary concerns are: a privatized fund could enter the market with a competitive advantage and how privatization of the guaranty fund would affect the residual market.

Program for Workman's Compensation Legislation. December 31, 1912. Industrial Accident Board of California.

This is a seminal report from the Industrial Accident Board to the Senate and Assembly of California, describing the purpose and need for enacting among other things, "A State Compensation Insurance Fund to enable employers to insure their compensation risks at what it is worth to do the insuring."

Reed, Ian (2002, June 12). Can California Workers' Compensation Avoid a Meltdown? Retrieved October 15, 2002, from Standard & Poor's Ratings Direct Web site: <http://www.standardandpoors.com/>

SCIF has almost tripled its net premiums to \$3.6 billion, competing aggressively on price. Price wars coincided with a rapid increase in the average cost of claims. Also, SCIF is exposed to a concentration of risk, especially from earthquakes and terrorism and mandatory increases in benefit levels.

Reed, Ian (2002, December 3). U.S. Commercial Lines Insurance Outlook 2003: A Study in Paradox. Retrieved January 10, 2003, from Standard & Poor's Ratings Direct Web site: <http://www2.standardandpoors.com>

The current hard insurance market is most strongly defined by terrorism, along with reduced investment returns, and widespread defaults by Corporate America. Reed also states that premium income must stay robust for some time to counteract the industry-wide reserve shortfall. The California State Compensation Insurance Fund, doubling in size over the past two years, also must act accordingly when rate setting as their capitalization continues to decline.

Reed, Ian (2002, July 9). U.S. Workers' Compensation Market Set to Follow California's Demise. Retrieved October 15, 2002, from Standard & Poor's Ratings Direct Web site: <http://www.standardandpoors.com/>

Workers' compensation is unpredictable coverage due to being susceptible to rising medical costs, political control of benefits, high susceptibility to fraud, and high variable costs (such as length of time to process claim). Also, along with the severity of each claim rising sharply, other concerns are present, namely the possible resurgence in claim frequency.

Ryan, Darian. (1995). Breaking Away from Rate Regulation. *Best's Review*, 97(7), 56. Retrieved October 15, 2002, from ABI/Inform Proquest database.

Companies that lack service and loss control capabilities, with limited product offerings are most susceptible to turmoil caused by open rating. Companies concentrated in the California market are subject to more volatile underwriting results. Also, the merging of health care companies and workers' compensation writers can jeopardize workers' compensation insurance companies by increased leverage and diminished profitability. Workers' compensation problems grow as benefit payouts continue to escalate. When compared to nine other competitive rating states, it was predicted that a dramatic rise in loss ratio would likely occur because of inadequate rates being charged. All this information was predicted in November of 1995.

State Funds Circle Their Surplus Wagons as States Face Budget Problems. (2002). *Workers' Comp Executive*, 12(20), 1,6.

Legislators aren't educated about the mechanics of how the insurance business works. They are especially naïve about the meaning of the term "surplus." For example, New York State Insurance Fund, the state government, borrowed \$1.29 billion from the fund's surplus between 1982 and 1990. It is very shortsighted to be robbing the workers' compensation

systems in this manner. This move could possibly escalate the rising price of workers' compensation.

State Fund Gets Help in Coaxing Davis to Lift Hiring Freeze. (2002). *Workers' Comp Executive*, 12(22), 3, 11.

A hiring freeze was imposed on the SCIF causing a disruption in the flow of benefits to injured workers as well as State Fund's ability to issue new policies in a timely manner. SCIF has been subjected to the hiring freeze although their money does not come from the Government General Fund. Michael Mattoch, chief consultant to the Assembly Insurance Committee, said that the committee also want to hold an oversight hearing on State Fund's hiring freeze after the legislative session starts in January 2003.

Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce of the US House of Representatives. (1990). *Failed Promises: Insurance Company Insolvencies*. Washington D.C.: US Government Printing Office.

The insurance industry sells the promise to pay all or part of the costs associated with some future event. An insurer's ability to pay, its solvency, must be subjected to proper regulation on a continuing basis, from the time premium payments are accepted until the time all anticipated insured events have occurred. The common elements among the insolvent and problem companies studied by the Subcommittee the following similarities were found: rapid expansion; over reliance on managing general agents; extensive and complex reinsurance arrangements; excessive under pricing; reserve problems; false reports; reckless management; gross incompetence; fraudulent activity; greed and self-dealing. The driving force was quick profits in the short run, with no apparent concern for the long-term well-being of the company, its policyholders, its employees, its reinsurers, or the public.

Why Workers' Compensation Insurance Rates Are Going Up (2002, March 6). Retrieved October 15, 2002, from California Department of Insurance Web site: http://www.insurance.ca.gov/RRD/RSU/Workers_Compensation.htm.

Lists four reasons why workers' compensation costs have risen in California:

1. Increased claim cost due to increased medical costs and increase severity of claims.
2. Intense competition to gain market share driving price down below cost.
3. Insolvencies of providers due to rates being inadequate to cover loss and underwriting.
4. Increase in pure premium to attempt to prevent more insolvency.

Workers' Compensation (2002). *Insurance Information Institute*. Retrieved January 16, 2003, from Insurance Information Institute Web site:
<http://www.iii.org/media/hottopics/insurance/workerscomp>.

The key facts are:

1. Losses are increasing.
2. Medical costs are rising.
3. Investment market is in a downturn

The cost of claims has been partially offset by the continued decline in the number of claims per worker. AB 749 sets no restrictions on who may be the treating physician or on the number of chiropractic visits, which in some states significantly pushes up costs.

Other cost factors are:

1. Increase in the amount of attorney involvement in some states.
2. Improved workplace safety.
3. Soaring costs of medical care.
4. The return-to-work process.
5. Size of residual markets.

Still another factor is large increases in reinsurance costs due to terrorist attacks on September 11.

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